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SECRETARY OF THE AIR FORCE

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Medical Service

MEDICAL READINESS PLANNING AND TRAINING

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive (AFPD) 41-1, *Health Care Programs and Resources* and DoD Instruction (DoDI) 1322.24, *Medical Readiness Training*. It sets procedures for medical readiness planning and training for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies. This instruction may be supplemented by headquarters (HQ), Air Reserve Component (ARC), and major command (MAJCOM) specific guidance. ***NOTE***: ANG is considered a MAJCOM throughout this instruction. References to medical treatment facility (MTF) are for active duty only. Maintain and dispose of records created as a result of processes prescribed by this instruction IAW AFMAN 37-139, *Records Disposition Schedule,* and AFI 33-332, *Air Force Privacy Act Program*.

This instruction requires collecting and maintaining information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. System of Records notice F036 AF PC C, Military Personnel Records System, applies.

(PACAF) This publication does not apply to the Air National Guard (ANG) and the Air Force Reserve Command (AFRC) units and members.

SUMMARY OF REVISIONS

This document is substantially revised and must be completely reviewed.

All chapters and attachments have been substantially changed to reflect current requirements for the execution, documentation and reporting of medical readiness planning and training.

(PACAF) This publication supplements AFI 41-106, *Medical Readiness and Training* dated 12 February 2003 and adapts the Medical Readiness Planning and Training policies and procedures to that of the Pacific Air Force (PACAF) mission and medical units. The revisions within this instruction provide PACAF medical units specific guidance, as well as clarify guidance found in AFI 41-106 as it relates to PACAF. *This supplement must be reviewed in its entirety*. The use of Expeditionary Medical Operations and Medical Readiness are to be used interchangeably and reflect current thought and nomenclature. New or revised material is indicated by a (|).

(PACAF) AFI 41-106, 12 February 2003, is supplemented as follows:

Chapter 1

FUNCTIONAL AREA RESPONSIBILITIES

1.1. United States Air Force Surgeon General (HQ USAF/SG). This individual will:

1.1.1. Establish medical policy.

1.1.2. Obtain and allocate resources.

1.1.3. Evaluate Air Force Medical Service (AFMS) support capabilities.

1.1.4. Ensure establishment of the Readiness Training Oversight Committee (RTOC) by charter to review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements.

1.1.4.1. This committee will meet at least semi-annually. The committee will update the medical readiness training community on current training initiatives and function as a forum to discuss and make recommendations for resolution of medical readiness training issues.

1.1.4.2. The membership of the RTOC is established by charter. The voting membership will consist of, at a minimum, one representative for each MAJCOM/SG (ACC, AETC, USAFA, AFMC, AFRC, AFSOC, AFSPC, AMC, ANG, PACAF, USAFE) and the RTOC Chair (HQ USAF/SGXT). Other non-voting members can be added at the discretion of the committee.

1.2. Air Force Inspection Agency (HQ AFIA/SG). This agency will:

1.2.1. Assess medical unit compliance to respond to wartime, humanitarian assistance and disaster response contingencies in accordance with (IAW) unit Status of Resources and Training (SORTS) Designed Operational Capability (DOC) Statements (AF Form 723, **Sorts DOC Statement**) and local plans.

1.2.2. Evaluate medical unit implementation of HQ USAF/SG and MAJCOM medical readiness policies and procedures.

1.2.3. Provide oversight and guidance to MAJCOMs that inspect using AFIA standards.

1.3. Major Command Surgeons (MAJCOM/SG) and Air National Guard (ANG) Air Surgeon (ANG/SG). These individuals will:

1.3.1. Provide policy to all subordinate commands and medical unit commanders on all aspects of medical readiness.

1.3.2. Ensure that medical units are properly organized, trained, and equipped to carry out all aspects of their wartime, humanitarian assistance, homeland security/defense, and disaster response missions. (For ARC units, this is additionally a Gaining MAJCOM (GMAJCOM) responsibility IAW AFI 10-301, *Responsibilities of Air Reserve Component (ARC) Forces.*)

1.3.3. Evaluate and monitor adequacy of medical plans, readiness and the training status of units. (For ARC units, this is additionally a GMAJCOM responsibility IAW AFI 10-301.)

1.3.4. Ensure that medical units comply with this instruction, USAF War and Mobilization Plan, Vol 1 policy, Operation Plan (OPLAN) requirements and other applicable directives.

1.3.5. Ensure force health protection guidelines for each area of responsibility (AOR) and for operations and exercises are available to subordinate units.

1.3.6. Assist unit level medical readiness officers (MRO), medical readiness noncommissioned officers (MRNCO) and civilian medical readiness managers (MRM) in resolving problems with their unit's readiness program.

1.3.6.1. (Added-PACAF) Medical Readiness Staff Assistance Visits (SAV) may be requested by the unit commander to the PACAF/SG indicating the specific areas of concern, desired time frame for the SAV, what specialties are requested, i.e. Training Program, Exercise Program, Reporting, UTC management, deployment management, disaster response, WRM management, etc.

1.3.6.2. (Added-PACAF) If a SAV is requested "out of cycle" from the normal HQ PACAF SAV timeframe of within one year of a Health Services Inspection, the unit should plan on funding the TDY.

1.3.7. Publish and review SORTS DOC Statements (AF Form 723) IAW AFI 10-201, *Status of Resources and Training System*.

1.3.8. Review the Medical Contingency Response Plan (MCRP) prior to publication, as specified in paragraph **4.2.5.** ANG Units will prepare an Emergency Management Plan, IAW HQ ANG/SG guidance. (Not applicable to AFRC.)

1.3.9. Ensure each assigned medical unit's Extended Unit Manning Document (EUMD) is postured to balance readiness, business-case and clinical currency requirements. Intra-command fragmentation of unit type code specialties will conform to current United States Air Force and Air Force Medical Service (AFMS) policies.

1.3.10. Grant waivers, as needed, of up to one Air Expeditionary Forces (AEF) training cycle for all medical training requirements identified in this instruction, with the intent that the unit will aggressively seek to meet requirements through alternate training opportunities. Units must maintain documentation of all waivers granted by the MAJCOM. MAJCOMs will forward a copy of all waivers to HQ USAF/SGXT for tracking.

1.3.11. Program and plan for Joint Chiefs of Staff (JCS), service and MAJCOM exercises and training, other than formal training (with the exception of formal Air Force Specialty Code (AFSC) and other formal course training).

1.3.12. Input, review, and monitor Air Force World-Wide Unit Type Code (UTC) Availability System (AFWUS) to ensure the UTCs are accurately assigned.

1.3.13. Compile, validate, and advocate for medical nuclear, biological and chemical (NBC) defense resource requirements through the budget and Program Objective Memorandum (POM) process, assess command NBC medical capability, maintain a master command NBC detection inventory, and serve as the medical HAZMAT point of contact.

1.3.14. Appoint the Command Bioenvironmental Engineers as the MAJCOM NBC Medical Defense Officer (MDO). Responsibilities include planning and coordinating the medical NBC program in conjunction with MAJCOM/SGX and Civil Engineering Readiness, and participation in MAJCOM Force Protection Councils.

1.3.14.1. (Added-PACAF) Responsibilities include MAJCOM POC for Homeland Defense/ Weapons of Mass Destruction (WMD) issues, working in coordination with unit level NBC MDO.

1.3.14.2. (Added-PACAF) Coordinate Homeland Defense/WMD matters with PACAF/SGX, SGMM and SGML function managers for a consistent and informed MAJCOM perspective and guidance to PACAF medical units.

1.3.15. Appoint the Command Public Health Officer (PHO) as the functional expert for Biological Warfare (BW) Disease Surveillance and Epidemiological response.

1.3.16. Appoint a trained provider as the MAJCOM NBC Casualty Management Officer (CMO). This officer is responsible for providing technical assistance to the unit NBC CMOs and coordinating training requirements with the MAJCOM NBC MDO for inclusion in program submissions.

1.3.17. (Added-PACAF) Conduct bi-monthly teleconferences with all PACAF medical units on the 2nd Wednesday of the month, commencing at 1330 hours, Hawaii Time, unless otherwise notified.

1.3.17.1. (Added-PACAF) PACAF/SGXO will send out an agenda to solicit topics of discussion and date, time, call-in number, etc. at least 2 weeks before the teleconference, with a fallow-up confirmed agenda no later than 1-week prior.

1.3.17.2. (Added-PACAF) Medical Readiness staff members are required to attend, however, it is strongly encouraged that others attend as well, for example, medical logistics/ War Reserve Materiel personnel, Squadron Commander, Education and Training representative and Unit WMD/ Homeland Defense Project Officer/NCO. Despite the presence of these individuals or not, information from the teleconference should be disseminated to appropriate personnel, as well as briefed at the next MRSF meeting.

1.3.18. (Added-PACAF) PACAF SGX has established a Medical Readiness webpage. The website should be visited at least monthly for updated information at:
https://www.hqpacaf.af.mil/sg/offices/sgx/SGX%20Index.htm

1.4. Air Education and Training Command Surgeon (HQ AETC/SG), 882nd Training Group (TRG), Air Force Materiel Command Surgeon (HQ AFMC/SG), and United States Air Force School of Aerospace Medicine (USAFSAM). These individuals/organizations will:

1.4.1. Obtain approval of curriculum content for any formal medical readiness training course from the USAF/SG through the RTOC prior to implementation.

1.4.2. Develop and make available current core medical readiness training lesson plans to all medical units.

1.4.3. Provide all SORTS reportable Medical Unit Readiness Training (MURT) during formal medical readiness courses.

1.5. Air Force Personnel Center Medical Directorate (HQ AFPC/DPAM). The directorate personnel will:

1.5.1. Maintain published guidance outlining the process for submitting applications for Category I continuing medical education (CME) and continuing education credit for medical readiness training courses.

1.5.2. Review and approve applications for Category I CME and continuing education credit when content meets the appropriate criteria.

1.6. Medical Unit Commander. The commander will:

1.6.1. Establish, evaluate and maintain the capability to provide and/or arrange for emergency care and transport of casualties resulting from wartime, humanitarian assistance, homeland security/ defense, and disaster response contingencies that are consistent with the unit's mission.

1.6.1.1. Ensure completion of all exercise and training requirements in this instruction.

1.6.1.2. Appoint, in writing, an AFSC-specific Functional Training Manager for each AFSC assigned to the unit. These individuals are responsible for AFSC-specific training as described in section **5.2.**

1.6.1.3. Ensure personnel are assigned to UTCs identified to support OPLAN requirements, AEF taskings, and homeland security/defense maintain training currency.

1.6.1.4. (Added-PACAF) Ensure Unit Deployment Managers identify fills for vacancies within 10 days of notification of a vacancy.

1.6.1.4.1. (Added-PACAF) Ensure that all personnel assigned to mobility positions have at least a SECRET security clearance which is revalidated every 10yrs of military service.

1.6.1.5. (Added-PACAF) Remove personnel from UTCs within 120 days of PCS date. Osan and Kunsan are exempt from this requirement. Do not deploy personnel that are due to PCS during a deployment; only deploy personnel that able to fulfill the entire deployment length. Exceptions are humanitarian assignments, emergency leave, etc.

1.6.1.6. (Added-PACAF) Ensure EMEDS Commander positions on the FFEP2 are only filled by Colonels (O-6) that (1) have had command experience or are in a command position, (2) have deployment experience, and (3) have a history of successful interaction with line counterparts. Exceptions must be approved by PACAF/SGX.

1.6.1.7. (Added-PACAF) When filling mobility positions on UTCs, the following guidance must be adhered to:

1.6.1.7.1. (Added-PACAF) Fill each position with an individual possessing the same AFSC, Grade and/or Skill-level as the UTC requirement. Refer to para 1.6.1.3.8 in this supplement for the sequence/priority of UTCs to fill. If an exact match is not available, then an appropriate "substitute" must be found. A substitute is any deviation from the required AFSC, grade or skill level and any other special experience identifier, i.e. SEI 496.

1.6.1.7.2. (Added-PACAF) If an exact match is not available, carefully review the mission capability (MISCAP) statement for authorized substitutions or other guidance on filling mobility positions, i.e. no substitutions allowed or IAW AFI 10-403 and/or WMP, Annex F, etc.

1.6.1.7.3. (Added-PACAF) Substitute grade and skill-levels IAW AFI 10-403, Para 5.3.2, i.e. one skill-level lower or two-skill levels of Control-AFSC (CAFSC) higher for enlisted positions and one grade lower (treat O-1s and O-2s as the same) or two grades of Duty-AFSSC (DAFSC) higher for officers. EXCEPTION: Chief Enlisted Manager (CEM) requirements must be filled by a CEM/E-9 resource.

1.6.1.7.4. (Added-PACAF) If a position is still unable to be filled with an authorized substitute and the MISCAP allows substitution IAW the WMP, Annex F, refer to the list of autho-

rized AFSC substitutions. Note: If an AFSC is not listed, then there are no authorized substitutions.

1.6.1.7.5. (Added-PACAF) If the unit still cannot fill a mobility position using the procedures above, submit a request for an exception or waiver to PACAF/SGX. It must be fully supported and not be a "temporary – less than 12 months" situation.

1.6.1.7.6. (Added-PACAF) The end result of any mobility assignment is that personnel assigned to the UTC be capable of performing duties associated with their required AFSC that enable the UTC/asset to meet its mission capability.

1.6.1.8. (Added-PACAF) If there are UTC personnel shortfalls, ensure personnel are assigned to "Deployment" coded UTCs before assigning them to an "Associate" A-UTC. Fill assigned UTCs in the following order from highest to lowest priority: FFMFS, FFEP1, FFGL2, FFDAB, FFEP2, FFEP6, FFGL3, FFCCT, FFEP3, FFGL4, FFEP5, FFEP4 and then all others. Make sure to use all possible substitution authority allowed, e.g. FFGLB is very liberal and should be filled after other UTCs that have very strict or no substitution authority. Bottom line: Fill EMEDS Basic UTCs first.

1.6.1.9. (Added-PACAF) Third Country National (TCN) deployment taskings will only be filled by personnel on Associate UTCs, e.g. FFEZZ, FFDZZ or FFZZZ.

1.6.2. Develop and publish a MCRP/EMP IAW **Chapter 4** of this instruction, and provide medical input to base-level mission planning documents.

1.6.2.1. AFRC medical and Aeromedical Evacuation (AE) units (active duty and AFRC) need not prepare the MCRP, but should be listed as manpower resources in the MCRP of co-located active duty medical units. Unit capability (i.e. number of personnel by AFSC, UTCs available, etc.) should be identified to support the co-located active duty unit MCRP. Non co-located AFRC units reflect their disaster response capability in applicable base-level plans. All AFRC units will document their wartime missions in the parent wing mobilization plan.

1.6.3. Ensure all medical personnel, regardless of component or status (i.e. ARC, Squadron Medical Element (SME), Active Component (AC), Independent Duty Medical Technicians (IDMTs)) receive the same opportunity for unit-level training.

1.6.3.1. (Added-PACAF) Reserve Components (RC) training must be coordinated through PACAF/SGXO prior to a PACAF medical unit accepting an ANG or AFRC unit request for training and/or Overseas Annual Training (OSAT). RC units are not allowed/authorized to deal directly with any PACAF medical unit until OSAT process is complete. If inappropriate contact does occur, contact PACAF/SGX immediately to resolve the issue with HQ AFRC or ANG/SGX points of contact. Units must request at least one OSAT per fiscal year. See **Attachment 14 (Added).**

1.6.4. Establish and chair an executive oversight committee IAW paragraph **2.1.**: Medical Readiness Staff Function (MRSF) for AC, and Executive Management Committee (EMC) for ARC.

1.6.4.1. (Added-PACAF) PACAF medical units are required to conduct MRSF meetings at least every other month as outlined below:

1.6.4.1.1. (Added-PACAF) Bedded medical facilities (3MDG, 35 MDG, 374 MDG and 51 MDG) and the Aeromedical Evacuation Squadron will conduct meetings every other month on the following schedule; Jan, Mar, May, Jul, Sep, and Nov.

1.6.4.1.2. (Added-PACAF) Non-bedded medical facilities (354 MDG, 18 MDG, 36 MDG, 15 MDG and 8 MDG) will conduct meetings every other month on the following schedule: Feb, Apr, Jun, Aug, Oct, and Dec.

1.6.4.2. (Added-PACAF) Draft MRSF meeting minutes and attachments will be sent to PACAF/SGX NLT 10 duty days post MRSF meeting date. Once approved and signed, send MRSF minutes to PACAF/SGX within 2 duty days. Submission must be via electronic package.

1.6.5. Appoint, in writing, a MRO, MRNCO, and/or MRM, as applicable. The appointment letter should include assignment as the certification official for medical readiness training (excluding individual AFSC-specific training). Ensure appointees apply through applicable channels (i.e. Formal Training/MAJCOM) for course J3OZR4000-005, Medical Readiness Planners Course immediately upon appointment. Training status will be documented in the MRSF/EMC minutes until training is complete. Medical Service Corps (MSC) officers who are appointed to this position and received medical readiness training during Comprehensive Functional Area Training at the Health Services Administration Course are considered trained. To maintain program continuity, personnel will remain in their position for a minimum of 24 months. Where possible, every effort will be made to avoid placing additional duties on the MRO/MRNCO/MRM unrelated to readiness. (Not applicable to the ANG.)

1.6.5.1. (Added-PACAF) When a newly assigned person is identified to fill a unit-level medical readiness position and has not been to the Medical Readiness Planners Course or Comprehensive Functional Area Training (CFAT)at the HSA course, immediately notify PACAF/SGXO training point of contact to request a quota for the next class available. The PACAF goal is for newly assigned medical readiness personnel to complete formal readiness training within 6 months of arriving at the unit or in route to remote assignment locations.

1.6.5.1.1. (Added-PACAF) For PACAF remote assignments, every effort will be made to accomplish training en route to new assignment. Therefore, units must identify as early as possible their replacements for readiness, contact the losing unit to determine the individual's readiness background and/or readiness training completion and notify the PACAF/SGXO training point of contact as soon as possible to coordinate a course quota, en route, if at all possible.

1.6.5.1.2. (Added-PACAF) Requirement for readiness personnel to remain in their position for a minimum of 24 months does not apply to PACAF remote (12 or 15 months; Korea and Guam) assignments, however, personnel are required to stay in readiness for entire tour. Exceptions must be coordinated with PACAF/SGX.

1.6.5.1.3. (Added-PACAF) Personnel assigned to the medical readiness office shall not be assigned to a UTC, if there are other personnel available with the same AFSC or an authorized substitutable AFSC based on the UTC MISCAP or War Mobilization Plan, Annex F Cross Utilization List. If any person within the readiness office "must" be assigned to a UTC, it should be to the least likely deployable asset for AEF, Sustainment or crisis response events. For example, patient decon team, blood transshipment center, blood donor center, patient retrieval team, hospital expansion, etc. Avoid assigning medical readiness personnel to any EMEDS package (Basic, 10 or 25 bed) UTCs. Medical readiness personnel serve the medical unit and HQs much more effectively when they remain at home station and work pre-deployment requirements and redeployment issues.

1.6.6. Appoint, in writing, a Medical Intelligence Officer/NCO (MIO) IAW paragraph **1.9.** Training status will be documented in the MRSF/EMC minutes until training is complete. (Not applicable to AE units.)

1.6.7. Appoint, in writing, a NBC Medical Defense Officer/NCO (MDO) IAW paragraph **1.10.**

1.6.8. Appoint, in writing, a provider who possesses the appropriate level of experience as the NBC Casualty Management Officer (CMO) IAW paragraph **1.11.**

1.6.9. Establish an in-house, decontamination capability IAW local requirements and AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*. Assign unit personnel as necessary, to train and exercise patient/casualty decontamination procedures IAW unit plans and policies. Units must be able to sustain an initial response based on the existing baseline capabilities until additional assistance can be mobilized.

1.6.9.1. Units will establish a patient decontamination capability at the unit if they plan to receive and treat casualties from a NBC or hazardous material (HAZMAT) event. A graduate of the Contingency/Counter-Terrorism Casualty Decontamination Course, course #B3AZYDECON-000, will lead and train this team. The team will be staffed to ensure the capability is readily available during all hours of unit operations. The MCRP Annex N will address operation of this team.

1.6.10. Ensure a process is in place to verify that pre-deployment medical screening and immunization requirements for all deploying forces (medical and non-medical) are identified and completed. This includes, but not be limited to, Preventive Health Assessment (PHA), DNA sampling, HIV testing, tuberculin skin testing, and medical/dental and mental health screening.

1.6.10.1. The PHA, Individual Medical Readiness (PIMR) Program is the current software program to manage these requirements, with the exception of mental health screening.

1.6.10.2. The Public Health office has the primary responsibility for pre and post deployment screening.

1.6.10.2.1. (Added-PACAF) Although Public Health has the primary responsibility for pre- and post- deployment processing, this program is multi-functional and requires the full cooperation and coordination of many individuals within the MTF, to include the deploying individual, supervisors, unit and squadron commanders and medical readiness staff.

1.6.10.2.2. (Added-PACAF) Tasked individuals will immediately notify the readiness and public health offices of impending deployment to ensure (1) the tasking is official and (2) to allow ample time to complete all pre-deployment requirements.

1.6.11. Appoint, in writing, a medical Exercise Evaluation Team (EET) Chief and representatives to the Wing EET IAW local requirements. The MRO, MRNCO, or MRM will not be the sole exercise evaluation team members. The medical readiness staff will identify exercise goals and objectives to the EET chief who develops the scenario, executes the exercise, and evaluates results in order to fully test medical readiness and fulfill exercise requirements, as outlined in this instruction. The team chief should have full knowledge of exercise requirements for medical personnel.

1.6.11.1. (Added-PACAF) The MRO, MRNCO or MRM will NOT be assigned to the Wing or MTF EET. With their responsibility for planning, coordinating and tracking all required training and exercises for the MTF this would be a conflict of interest and over tax these individuals. How-

ever, there must be a close relationship between the EET chief and medical readiness staff for effective and efficient accomplishment of all training and exercise requirements.

1.6.12. Review and initial the SORTS DOC statement (AF Form 723) annually and as changes occur, IAW AFI 10-201, *Status of Resources and Training System*.

1.6.13. Appoint, in writing, a unit SORTS monitor and alternate IAW AFI 10-201.

1.6.14. Review, certify, and approve unit SORTS reports IAW AFI 10-201.

1.6.15. Appoint, in writing, the installation Self-Aid and Buddy Care (SABC) Monitor IAW AFI 36-2238, *Self-Aid and Buddy Care Training*. (Not applicable to AE units.)

1.6.16. Review Medical Readiness Decision Support System (MRDSS) data monthly. AFRC will review Web Based Integrated Training System (WBITS) training data and MRDSS Status Report monthly.

1.6.17. Provide commander's UTC readiness assessment comments monthly for certification by the wing commander and reporting in the AEF UTC Reporting Tool (ART). Information submitted should follow wing guidance and AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces*.

1.6.18. Chair the MRSF/EMC.

1.6.18.1. Approve the agenda and meeting minutes.

1.6.18.2. Ensure required attendance and determine additional participants.

1.6.18.3. Identify training and exercise funding requirements/needs to wing commander and MAJCOM/SG.

1.6.19. Approve medical readiness support agreements with agencies on and/or off-base, military and/or civilian, as appropriate, in order to fully execute the MCRP/EMP.

1.6.19.1. Direct the MRO/MRNCO/MRM to provide, develop, and coordinate the agreements with the appropriate federal, civilian and base agencies.

1.6.20. Establish, organize, and maintain the Medical Control Center (MCC) IAW MCRP/EMP guidance and AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning And Operations*.

1.6.21. Establish a process for conducting daily disease surveillance to provide early detection of unusual disease trends that may suggest a suspected or confirmed covert biological attack. Ongoing medical surveillance may provide the first indication of attack. Liaison with other MTFs in local area that treat beneficiaries to obtain disease incidence data. (Not applicable to ARC.)

1.6.22. Receive a medical intelligence briefing from the MIO at least quarterly. Document completion in the MRSF/EMC minutes. (Not applicable to ARC.)

1.6.23. (Added-PACAF) Budget for TDY funding and attendance for at least one person, preferably two from the medical readiness office to attend the annual PACAF Medical Readiness Workshop conducted on Hickam AFB, Hawaii. Workshop will be scheduled for 4 days and on-base billeting will be pursued.

1.6.24. (Added-PACAF) Nominate experienced MTF personnel to augment/support the PACAF inspection team. PACAF/SGX and/or the medical inspector on the PACAF/IG team will solicit augmentees, however, nominees can be submitted at anytime to PACAF/SGX as well. Funding is provided by PACAF/IG. PACAF Operational Readiness Inspections and Unit Compliance Inspections

augmentations are great opportunities to prepare for a unit inspection, especially for units with upcoming inspections.

1.6.25. (Added-PACAF) Ensure all active duty military personnel assigned to PACAF medical or Aeromedical Evacuation units have a blue cover Tourist U.S. passport (not a government official passport) or the unit has an established process developed to obtain a passport within 24 hours. This is imperative as personnel who are not assigned to standard deployable UTCs, can be tasked to support real-world contingencies and operations, humanitarian missions, and Joint Exercises, which may require personnel to travel outside the United States. Flight Surgeons, EMEDS physicians/providers, IDMTs, nurses, 4N0, 4A1, 4E0, 4B0, 043H3, 043B3 assigned to associate UTCs should be given priority.

1.6.25.1. (Added-PACAF) Guidance for reimbursing members can be found in Joint Federal Travel Regulation (JFTR) Volume1 Uniformed Service members in **Chapter 4**, under Part F paragraph U4550

1.6.26. (Added-PACAF) Appoint in writing disaster team chiefs.

1.7. Medical Readiness Officer (MRO), Medical Readiness Non-Commissioned Officer (MRNCO), and Medical Readiness Manager (MRM), henceforth called the MR Office unless a paragraph addresses one specifically. These individuals will:

1.7.1. Serve in the position for a minimum of 24 months. (Not applicable to the ANG.)

1.7.1.1. (Added-PACAF) Ensure Readiness personnel assigned to a PACAF remote tour, shall remain in medical readiness for the duration of their tour (Kunsan, Osan and Andersen).

1.7.2. Attend J3OZR4000-005, Medical Readiness Planners Course (MRPC) within 12 months of assignment to MRO/MRNCO/MRM duties. Track attendance as directed in paragraph **1.6.5.** (Not applicable to the ANG.)

1.7.2.1. (Added-PACAF) Review newly assigned personnel filling unit-level medical readiness positions, to determine readiness background and whether they have attended the Medical Readiness Planners Course or CFAT during the Health Services Administrative course. If training has not been completed, immediately notify PACAF/SGXO training point of contact to request a quota/class date that will accommodate the unit's schedule. PACAF's goal for newly assigned medical readiness personnel is to have required personnel complete formal readiness training within 6 months of arrival.

1.7.2.2. (Added-PACAF) For PACAF remote assignments, 12 or 15 months in length, every effort will be made to accomplish formal training before arriving or en route to PACAF duty location. As such gaining units must identify replacements for readiness positions as early as possible. Establish contact with losing units to determine individual's readiness background and/or readiness training completion and coordinate with PACAF/SGXO training point of contact to secure a course quota. This is necessary to maintain continuity and readiness staff effectiveness during their remote assignment.

1.7.3. Manage the preparation, coordination and publication of the MCRP/EMP and medical input to other applicable base-level plans. (MCRP not applicable to AFRC.)

1.7.4. Coordinate with medical logistics staff to ascertain the deployability status of War Reserve Materiel (WRM) assemblages.

1.7.5. Provide the medical information needed for base-level mission planning documents. With the assistance of the MIO, ensure the medical input includes the current and potential medical intelligence risks or threats.

1.7.6. Ensure that training programs are developed, conducted and properly documented.

1.7.6.1. (Added-PACAF) PACAF MTFs will ensure all medical readiness training programs, i.e. RSV, Disaster Team, UTC, and Field training are fully developed and conducted within required time frames. Readiness Skills Verification (RSV) are those tasks required to be proficient in an individual's AFSC. Disaster Team Training are skills required to be proficient in the accomplishment of tasks related to a specific disaster team, e.g. MCC, security, alternate facility team, etc. Training documentation will be accomplished utilizing the Readiness and Training (RAT) database or other electronically built databases that provide quantifiable information on each AFSC assigned to the MTF. Training databases must be complete and useable without explanation. Information that must be included are dates, training objectives, instructors, etc. Information must be available and sufficient to validate accomplishment of training.

1.7.6.2. (Added-PACAF) PACAF Medical Readiness Offices will forward their approved/ updated Training and Exercise event calendars to HQ PACAF/SGX on a quarterly basis, NLT the first duty day of the month as follows: Feb, May, Aug, and Nov. The calendar will include, but is not limited to, the following known or planned events:

1.7.6.2.1. (Added-PACAF) MTF/AES and wing/base exercises (MARE, ARE, MASCAL, WMD, etc.)

1.7.6.2.2. (Added-PACAF) MTF/AES (include MURT) and wing/base training events

1.7.6.2.3. (Added-PACAF) CCATT/AE/EMEDS/Blood teams/other UTCs/Disaster Team Training/ Exercise Events (this is separate from RSV training)

1.7.6.2.4. (Added-PACAF) Formal course attendance, JTF Surgeon Seminar, Joint Medical Operations Command Course, C-STARS, EMEDS, etc.

1.7.6.2.5. (Added-PACAF) HSI/JCAHO/UCI/ORI or other unit/wing inspection or exercise (ORE, PEN CERE, etc.).

1.7.6.2.6. (Added-PACAF) PACOM Joint Exercise taskings (RSO&I, UFL, Terminal Fury, etc.).

1.7.6.2.7. (Added-PACAF) NAF sponsored Field or Command Post Exercises.

1.7.6.2.8. (Added-PACAF) Scheduled Base Support Plan (BSP) Conference or Site Visit.

1.7.6.2.9. (Added-PACAF) Overseas Annual Training (OSAT) events.

1.7.6.2.10. (Added-PACAF) Tasking to participate in JTF-FA missions, IHS humanitarian exercises / missions and any other significant activity PACAF/SGX should be aware of—the goal is to keep PACAF/SGX informed of all unit level activities and involvement in both wing and outside events.

1.7.6.3. (Added-PACAF) Requests to use/take WRM assets "off-line" for training purposes must be requested through PACAF/SGX no later than 60 days before the event. WRM will not be used without prior approval from PACAF/SGX and SG. (EXCEPTION: A real-world emergency with authorization by the medical unit Commander). However, notification must be made to the

PACAF/SGX when WRM is used for a real world event. Refer to **Attachment 9 (Added)** for the WRM Request format and specific guidance regarding deployable/non-deployable WRM.

1.7.7. Ensure MRDSS data (including every available data element) is updated each month, or as significant changes occur (defined as 25 percent or greater), in MRDSS or the current reporting system. Present this information monthly to the unit commander. ANG and AFRC members will provide their MRDSS information to the EMC at least quarterly. AFRC will interface with MRDSS through WBITS, or its replacement reporting system. AFRC medical units will update the reporting system monthly.

1.7.8. Integrate the medical readiness portion of the AFIA/SG Health Services Inspection (HSI) Guide into the unit self-inspection program. Brief the MRSF/EMC as appropriate. AE will use applicable portions of the HSI guide.

1.7.9. Develop and coordinate medical readiness Memorandums of Agreement (MOA) or Memorandums of Understanding (MOU) with the appropriate federal, civilian and base agencies to include collocated units IAW paragraph **4.1.3.3.** of this instruction. Do not duplicate support agreements with base agencies listed in the Wing/Base Inter-Service Support Agreement (ISSA). Instead, denote the support provided under the ISSA in the Basic Plan. Should support be required from a base agency not be listed in the ISSA, MOAs/MOUs are required. When drafting these documents, ensure they are compliant with applicable Department of Defense, Federal, State, and local directives. When coordinating the MCRP/EMP with supporting entities, use AF Form 1768, **Staff Summary Sheet (SSS)**, to clearly outline what support is required. Signature of agencies on the SSS (AF Form 1768) denotes understanding and commitment. Copies of all coordination SSS (AF Form 1768) and MOAs/MOUs listed in the MCRP/EMP will be kept in the medical readiness office. Ensure the Executive Staff, MRSF/EMC, Wing/XP, Wing/JAG, and other agencies as appropriate, conduct initial and annual review of all agreements. ***NOTE***: ARC will accomplish this through the Base Support Plan (BSP).

1.7.10. Develop a master MURT and exercise plan IAW the frequency of training and exercises denoted in **Attachment 3** and **Attachment 7**, and based on the AEF cycles. Ensure plan outlines training subject requirements, such as to whom it applies, responsibilities for conducting it, and how make-up training will be accomplished. Additionally, provide a brief definition of exercise requirements listed in **Attachment 7**. Prior to the beginning of each calendar year, submit MURT/exercise plan to MRSF/EMC for approval. Forward approved MURT/exercise plan to the MAJCOM/SG for information only. AFRC units submit to appropriate NAF RSG/SG. ANG units will only submit upon request of ANG/SGX or GMAJCOM/SGX.

1.7.11. Prepare and submit SORTS report IAW AFI 10-201.

1.7.11.1. (Added-PACAF) PACAF Unit Medical Readiness Offices will prepare and submit SORTS Reports IAW AFI 10-201, AFI 10-201/PACAFSUP1, and the "SORTS Checklist". Refer to **Attachment 1.**

1.7.11.2. (Added-PACAF) Guidance as to when a unit must prepare an out of cycle SORTS report can be found in AFI 10-201, para 2.4, Frequency of Reporting C-level Data Elements. This document states that the CJCS policy requires unit C-level changes to reach the National Military Command Center (NMCC) *within 24 hours* after a reportable event or upon direction of the CJCS, the Services, or CRO. GSORTS is the readiness reporting system for the NMCC. AF units will report C-level changes *within 24 hours* of the change for each SORTS DOC Statement. Report when there are changes in the Overall C-level, Overall Reason Code, measured area levels, measured

area reason codes, PCTEF, D, E, F, and G reason codes (DEFG), GWD updates, forecast dates, or when directed by the measured unit commander. If a unit is committed to combat operations (i.e., located in a combat zone), report C-level data as described above or at the frequency and level of detail as directed by the CJCS.

1.7.11.3. (Added-PACAF) If a SORTS report is required or submitted outside the normal monthly report time frame required by the Wing, the unit must (1) contact/coordinate with PACAF/SGX regarding the reason for the report, the GWD and actions needed to ensure GWD is successfully met, (2) contact PACAF/SGXO within 24-hours of the command post inputting the out-of-cycle report. Out-of-cycle reports can be requested/submitted for the following reasons: receipt of a new DOC statement, any change in rating due to deployment, change up/down in any sub-area, change in operational equipment status or whenever directed by PACAF/SGX or Wing/CC.

1.7.12. Schedule MRSF meetings. (Not applicable to ARC.) ARC MRO/NCO will ensure required material is provided to the EMC at least quarterly.

1.7.12. (PACAF) AFRC MRO/NCO will report medical readiness issues quarterly through the EMC. The ANG EMC function will occur IAW HQ ANG supplemental guidance.

1.7.12.1. (Added-PACAF) PACAF MROs will conduct MRSF meetings every other month as indicated in para **1.6.4.1. (Added)** thru **1.6.4.2. (Added)** and in accordance with guidelines outlined in **Chapter 2**.

1.7.12.2. (Added-PACAF) If an issue/item/discrepancy/deficiency/ remains open for three consecutive MRSF meetings, the following must be addressed in the fourth MRSF meeting minutes for PACAF/SGX review/action:

1.7.12.2.1. (Added-PACAF) Detailed discussion regarding the issue.

1.7.12.2.2. (Added-PACAF) Summary of situation.

1.7.12.2.3. (Added-PACAF) Corrective action(s) taken to date and reasons for issue remaining open.

1.7.12.2.4. (Added-PACAF) Original estimated completion date, and specific assistance required from HQ PACAF, if necessary.

1.8. Medical Intelligence Officer (MIO/MINCO). This individual will (not applicable to AE):

1.8.1. Hold the AFSC of a Public Health Officer (PHO) (43HX)/Public Health NCO (PHNCO) (4E0XX). For units without a PHO/PHNCO, contact the Command PHO for guidance. ***NOTE***: ARC units tasked with the Aerospace Medicine Function (UTC FFDAE for AFRC and UTC FFGK1 for ANG) will be responsible for this duty.

1.8.2. Immediately upon assignment to this position, apply for the Contingency Operations Course, course #B3OZYCONOP-000, if haven't previously attended. The MIO/MINCO will also apply to their MAJCOM/SGX for instructions on registering to attend the Introduction to Medical Intelligence Course located at Armed Forces Medical Intelligence Center (AFMIC), Ft. Detrick, MD. The Public Health Apprentice, Officer, or AFMIC course may be attended in lieu of the Contingency Operations Course for ARC personnel assigned as MIO/MINCO.

1.8.2.1. (Added-PACAF) Newly assigned MIO/MINCO to PACAF MTFs are required to immediately notify HQ PACAF/SGGM of the training requirement if the member has not already been to the Contingency Operations Course, course #B3OZYCONOP-000, or an approved substitute.

1.8.3. During the pre-deployment phase, work with line intelligence, collocated MTF, MIO, or MAJCOM/SGPM personnel, to obtain a medical intelligence assessment to include disease risks, environmental health hazards, host nation medical capabilities/facilities, cultural-specific health issues unique to the host nation population, host nation chemical and biological warfare medical defense capabilities. Use all medical intelligence sources available to prepare and present the medical threat assessments at deployment locations so that medical risks are included in pre-deployment medical threat briefs to all deploying forces.

1.8.3.1. (Added-PACAF) The PACAF Public Health Officer's office symbol is PACAF/SGGM, a function within the Aeromedical Division.

1.8.4. Provide, or arrange for, the provision of medical intelligence briefings to deploying personnel.

1.8.5. During the post-deployment phase, work with medical personnel to complete the After Action Report IAW paragraph **6.9.**

1.8.6. Provide the medical unit commander and his/her executive staff a quarterly medical intelligence briefing at the MRSF. This briefing will include assessment of local threats, threats to potential deployment sites, current information on vaccines and antidotes, possible disease surveillance trends, capabilities to identify chemical or biological agent threats, and limitations to protective measures, if any. Utilize appropriate procedures for disseminating classified information.

1.8.6.1. (Added-PACAF) PACAF medical units will conduct MRSF meetings IAW paragraphs **1.6.4.1. (Added)** thru **1.6.4.2. (Added)** of this Supplement, therefore, the medical intelligence briefing will align accordingly, based on unit's MRSF meeting schedule.

1.9. Nuclear, Biological, Chemical (NBC) Medical Defense Officer/NCO (MDO) . This individual will:

1.9.1. Be a Bioenvironmental Engineer (BEE) (43E3X) or a Bioenvironmental Engineering Technician (4B0X1). For units without a BEE/NCO, contact the Command BEE for guidance. The NBC MDO will be the unit functional for NBC issues. The PHO will be the unit consultant on Disease Surveillance and Epidemiological response.

1.9.1.1. (Added-PACAF) The PACAF Command BEE Officer's office symbol is PACAF/SGGB, a function within the Aeromedical Division.

1.9.2. Be a functional resource to the medical readiness office during the planning and execution of unit NBC training. In concert with the medical readiness office, orchestrate unit medical NBC programming and budgeting. Assist the medical readiness office with tracking and documenting NBC unit training.

1.9.2.1. (Added-PACAF) PACAF Medical Readiness offices, in conjunction with the NBC MDO and Human Resources/Education and Training, will ensure and track Medical Management of Biological and Chemical Warfare Casualties (MMBCWC) training to all providers and first responders. MMBCWC is a one-time requirement and units are expected to be at or "very near" 100% at all times.

1.9.2.2. (Added-PACAF) If a newly assigned member has not already received training or it can not be verified on the member's AF 1098 within their Provider Activity Folder or Competency Training Folder, MMBCWC will be provided during the initial orientation to the MTF.

1.9.2.3. (Added-PACAF) Quarterly, NLT the 15th of the following months (Jan, Apr, July and Oct), the Medical Readiness Office will provide MMBCWC training statistics to the PACAF/SGX office as follows: actual number of providers and first responders assigned and trained, and the associated trained percentage. For personnel requiring MMBCWC training, provide the provider's Duty AFSC, date they arrived new duty location and unit/base they PCS'd from and date training will be accomplished/completed in the quarterly report to PACAF/SGX.

1.9.3. Immediately upon assignment to this position, apply for the Bioenvironmental Engineering Nuclear, Biological and Chemical Operations Course, course #B3AZY4B0X1 017, if not previously attended and appropriate for individual's AFSC.

1.9.3.1. (Added-PACAF) Request formal course attendance for NBC MDO through the PACAF BEE (PACAF/SGGB or SGC).

1.9.4. Assist NBC CMO to identify and make known to clinicians/providers, trainers, and/or other medical operational personnel (including NCOs), applicable formal training opportunities for which they can apply.

1.9.5. Provide the NBC Casualty Management Officer (CMO) threat assessment information necessary for planning the clinical response to an NBC or WMD event. This assessment must include consideration for intentional and unintentional releases from local industrial facilities (toxic industrial chemicals/materials). The PHO will assist the NBC CMO in the development of clinical response to BW events.

1.9.6. Evaluate NBC aspects of unit-level medical plans, to include the MCRP/EMP and applicable MOUs/MOAs with local health care facilities.

1.9.7. Work closely with base Civil Engineering (CE) Readiness Flight personnel to verify that base NBC training and medical NBC training provide consistent instruction.

1.9.8. Assist CE Readiness Flight in the development of the installation NBC detection plan. The NBC MDO will serve as functional expert to the Wing Survival Recovery Center (SRC) and to the Wing NBC Cell and NBC Reconnaissance Teams. Assist CE Readiness Flight in the development of the installation NBC detection plan, and will perform NBC surveillance in conjunction with CE readiness. (Not applicable to AE units.)

1.9.9. Provide subject-matter expertise to installation commanders on NBC effects, health-based risk assessment and operations in NBC environments, in coordination with the PHO.

1.9.10. Inspect all medical unit NBC detection equipment for proper maintenance. Train medical personnel designated to operate the equipment prior to use.

1.9.11. Coordinate with the base CE Squadron, base fire department, assigned healthcare clinician/provider and BEE concerning peacetime HAZMAT response. The NBC MDO is the primary medical focal point on HAZMAT issues. Determine procedures for receiving patients after gross field decontamination by base HAZMAT (fire department) personnel, and personnel who may bypass scene control and arrive directly at the medical unit. Assist the medical readiness office and medical unit leadership in incorporating procedures for managing contaminated patients in unit plans and policies.

1.9.12. Act as the medical unit POC for base and unit Force Protection Working Groups and Vulnerability Assessment Teams (PHO is additional POC). See AFI 10-245, *Air Force Antiterrorism (AT) Standards*.

1.9.13. Ensure medical first responders receive the appropriate level of Hazardous Waste Operations and Emergency Response (HAZWOPER) training IAW the requirements established in AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*.

1.9.14. Conduct an assessment of local industrial facilities (on and off base) that may be of consequence to base operations if toxic industrial chemical/toxic industrial material (TIC/TIM) materials released. Inform the MRSF and Wing Force Protection Working Group of the results of this analysis.

1.10. NBC Casualty Management Officer (CMO). This clinician/provider will:

1.10.1. Assist the NBC MDO with the assessment of the clinical capability and the impact of a NBC threat, recommend appropriate actions to protect forces, and is the medical POC for the treatment portions of the MCRP Annex N and the EMP.

1.10.2. Coordinate with the PHO on BW related planning, training, epidemiological response and to obtain medical surveillance data.

1.10.3. Assist unit training manager in developing and implementing a clinician/provider focused NBC treatment training program. Seek formal training course quotas from the MAJCOM readiness training POC. Identify and make known to physician trainers, physicians, and/or other medical operational personnel (including NCOs), applicable formal training opportunities for which they can apply. This includes courses on prevention and/or treatment of casualties of Weapons of Mass Destruction (WMD) to include nuclear, biological, and chemical agents. Formal courses are available through: United States Army Medical Research Institute of Infectious Diseases (USAMRIID), Ft. Detrick, MD, United States Army Medical Research Institute of Chemical Defense (USAMRICD), Aberdeen Proving Grounds, MD, and Armed Forces Radiobiology Research Institute (AFRRI), Bethesda, MD. Formal courses are available in residence, locally, where trainers are available, or through distributed learning programs. Ensure appropriate training materials are available to local AFSC-specific training programs.

1.10.4. Attend NBC training, i.e., Medical Management of Biological, Chemical and Radiation Warfare courses, in-residence when central funding available, or by satellite broadcast, or through distance learning.

1.10.4.1. (Added-PACAF) Request formal course attendance for NBC CMO through the PACAF BEE (PACAF/SGGB or SGC) for the Medical Management of Biological, Chemical and Radiation Warfare Course.

1.10.5. Ensure all clinicians/providers receive medical NBC training IAW **Attachment 3**. Coordinate training and training plan with the NBC MDO and MR Office as outlined in paragraph **1.10.2.**

1.11. Medical Exercise Evaluation Team (EET) Chief. This individual will:

1.11.1. Select EET members to assist in the evaluation of medical play during unit and wing exercises.

1.11.2. Attend EET training as required by the wing XP office.

1.11.3. Coordinate exercise goals and objectives with the MRO and the MRSF.

1.11.4. Develop exercise scenarios that fully test medical readiness capability..

1.11.5. Direct exercises according to exercise schedule of events.

1.11.6. Evaluate exercises using established criteria.

1.11.7. Provide unit and wing commander detailed report of exercise outcome/evaluation within 7 days of end of the exercise. This evaluation will be included in the exercise After Action Report (AAR).

1.12. (Added-PACAF) Disaster Team Chiefs will:

1.12.1. (Added-PACAF) Develop MCRP annexes IAW prescribed formats.

1.12.2. (Added-PACAF) Develop annex/disaster team checklists.

1.12.3. (Added-PACAF) Develop annual disaster team training schedule, objectives and training plans.

1.12.4. (Added-PACAF) Develop exercise objectives for inclusion in local and wing exercise events to ensure the team will be activated.

1.12.5. (Added-PACAF) Maintain current team rosters.

1.12.6. (Added-PACAF) Ensure team training is accomplished and documented.

1.12.7. (Added-PACAF) Maintain disaster team notebook IAW prescribed formats.

1.12.8. (Added-PACAF) Manage disaster team supplies and equipment.

1.12.9. (Added-PACAF) Manage and inventory WMD supplies and equipment, if applicable. Monthly updates must be provided to Readiness to update MRDSS.

Chapter 2

MEDICAL READINESS STAFF FUNCTION (MRSF)

2.1. MRSF purpose: To provide executive oversight for all medical readiness issues to include the organizing, training and equipping of all assigned personnel, and to ensure the unit is able to meet their assigned wartime, humanitarian assistance, homeland security/defense, and disaster response missions. Oversight includes the processes, as identified in **Chapter 1** of this instruction, involved in support of the installation readiness missions. ARC MRSF responsibilities are fulfilled through the EMC with medical readiness being on the agenda at least quarterly. Paragraph **2.2.** provides a list of items that should be reviewed at the MRSF/EMC.

2.1.1. MRSF meetings will be conducted, at a minimum, quarterly. AFRC will report medical readiness issues quarterly through the EMC.

2.1.1.1. (Added-PACAF) Refer to paragraphs **1.6.4.1. (Added)** thru **1.6.4.2. (Added)** in this Supplement for PACAF frequency and schedule.

2.1.2. The ANG EMC function will occur IAW HQ ANG supplemental guidance.

2.2. Minimum Standard Agenda Items.

2.2.1. Status report of open items from previous minutes.

2.2.1.1. (Added-PACAF) Include brief summary of problem, name of Action Officer (AO), corrective action and results, any limiting factors influencing ability to resolve/close the item and estimated closure date of item.

2.2.1.2. (Added-PACAF) If an issue/item/discrepancy/deficiency remains open for three consecutive MRSF meetings, a detailed discussion regarding the issue, summary of situation, corrective action(s) taken to date and reasons for issue remaining open, original estimated completion date, and specific assistance required from HQ PACAF, if necessary, must be attached to the next MRSF minutes for PACAF/SGX review/action.

2.2.2. SORTS/MRDSS, update as applicable. Classified material not required, but if given must be to the attendees classification levels. Include UTC manning, training, and WRM status, as applicable.

2.2.3. Training and exercise schedule update.

2.2.3.1. (Added-PACAF) Overseas Annual Training (OSAT) events scheduled or requested. PACAF/SGX and the respective RC MAJCOM must initially coordinate all Reserve Component (RC) training events. If a PACAF unit is contacted directly by a RC unit, immediately inform PACAF/SGX. Refer to **Attachment 14 (Added)** for OSAT process. Include these items in the Training and Exercise event calendar on a quarterly basis. Refer to paragraph **1.7.6.2. (Added)**

2.2.4. Deployment After Action Reports, to include discrepancies and status of follow-up until closure, as applicable.

2.2.5. Results of inspections (i.e., self-inspections, Operational Readiness Inspections (ORI)/Operational Readiness Exercises (ORE), HSIs, Staff Assistance Visits (SAV), Aircrew Standardization Evaluation Visits (ASEV), etc.).

2.2.6. Post-exercise or incident summaries review and follow-up activities. Exercise findings/deficiencies will be tracked as open items until corrective action(s) have been implemented and tested.

2.2.7. Status of Medical Unit Readiness Training. At a minimum, this training must include core, deployment, field, and just-in-time (JIT) readiness training requirements as applicable to unit mission. Other items may include Combat Arms Training and SABC statistics, MRO/NCO and MIO/NCO training, and other locally generated requirements. See **Attachment 3**.

2.2.7.1. AFSC-specific training status. Include a review of elements that exceed unit-training capabilities and therefore cannot be satisfied at the unit. Validation by the MRSF must be documented.

2.2.8. Review required plans and MOUs/MOAs.

2.2.9. Team training status (i.e., Disaster teams, UTC-specific team training, etc.).

2.2.10. Status of deployed personnel.

2.2.10.1. (Added-PACAF) Include unit personnel deployed for AEF; PACOM Joint Exercises, (RSO&I, UFL, Terminal Fury, Tandem Thrust, etc.), Humanitarian Missions/Operations, and others deployed in "other than TDY or formal schools" status. Update MRDSS to reflect deployed personnel status. Include these items in the Training and Exercise event Calendars on a quarterly basis. Refer to paragraph **1.7.6.2. (Added)**

2.2.11. Quarterly MIO briefing (not applicable to AE).

2.2.11.1. (Added-PACAF) MIO briefings will be aligned with MRSF meeting schedule outlined in paragraphs **1.6.4.1. (Added)** thru **1.6.4.2. (Added)**

2.2.12. Additional MAJCOM requirements, as directed.

2.2.12.1. (Added-PACAF) Homeland Defense/Weapons of Mass Destruction materiel status.

2.3. MRSF Minutes.

2.3.1. Meeting minutes will provide a clear, concise summary of discussions and events. This document will include enough detail and explanation of historical events to fully describe all issues being discussed. Use MRSF minutes to document unit MCRP/EMP review and approval, as well as MURT training and exercise schedule coordination and approval. Attachments must include copies of post-exercise or incident summaries, AAR and other documents as directed by MAJCOM.

2.3.2. Copy of MRSF minutes will be sent to MAJCOM/SGX for review IAW MAJCOM guidance. EMC minutes are not required to be sent to AFRC/ANG.

2.3.2.1. (Added-PACAF) MRSF meeting minutes and attachments will be sent to PACAF/SGX NLT 10 duty days after MRSF meeting date.

2.4. Required MRSF Membership.

2.4.1. Unit Commander (chairperson)

2.4.1. (PACAF) (VOTING)

2.4.2. MRO/MRNCO/MRM (Action Office)

2.4.2.1. (Added-PACAF) MRO – VOTING

2.4.2.2. (Added-PACAF) MRNCO/MRM – NON VOTING

2.4.3. Executive management team

2.4.3.1. (Added-PACAF) Deputy Commander – VOTING

2.4.3.2. (Added-PACAF) Squadron Commanders – VOTING

2.4.3.3. (Added-PACAF) SGH, SGN, SGD – NON VOTING

2.4.3.4. (Added-PACAF) Group Superintendent – NON VOTING

2.4.4. NBC MDO

2.4.4. (PACAF) (NON VOTING)

2.4.5. NBC CMO

2.4.5. (PACAF) (NON VOTING)

2.4.6. Medical Logistics Officer

2.4.6. (PACAF) (VOTING)

2.4.6.1. (Added-PACAF) WRM Manager – NON VOTING

2.4.6.2. (Added-PACAF) Medical Logistics Superintendent – NON VOTING

2.4.7. MIO

2.4.7. (PACAF) (NON VOTING)

2.4.8. Medical EET Chief

2.4.8. (PACAF) (NON VOTING)

2.4.9. Reserve Affairs Liaison, when appointed

2.4.9. (PACAF) (NON VOTING)

2.4.10. Other individuals as directed by the chairperson, e.g., RMO, MCRP/EMP team chiefs, Unit Deployment Manager (UDM), UTC team chiefs, AFSC-specific functional managers, etc.

2.4.10. (PACAF) (NON VOTING)

2.4.10.1. (Added-PACAF) Education and Training – NON VOTING

2.4.10.2. (Added-PACAF) Homeland Defense/WMD Unit Project Officer/NCO (if different from NBC MDO).- NON VOTING

Chapter 3

CONTINENTAL UNITED STATES (CONUS) MEDICAL SUPPORT

3.1. Wartime Mission of the CONUS Air Force Medical System. All CONUS-based medical units will continue to arrange for medical services for all eligible beneficiaries, unless their MAJCOM informs them otherwise. When directed by official decree of the President of the United States or the Secretary of Defense, Joint Forces Command (JFCOM) will integrate the Services' as well as other governmental, and non-governmental agencies' CONUS medical resources to assist in the mobilization and deployment of forces to support Outside CONUS (OCONUS) Combatant Commanders and to provide evacuation and treatment for patients returning to CONUS from major theater wars. Within 72 hours of receipt of an Execute Order (EXORD), JFCOM Service Component Commanders (Air Combat Command) will coordinate to ensure that all DoD MTFs discharge or transfer current inpatients as appropriate; obtain material and staffing necessary; and take other actions as required to provide the operating bed capabilities. Services and DoD Lead Agents are required to continue to provide peacetime levels of healthcare to the beneficiary population. Typically, if the local MTF cannot provide adequate medical care to beneficiaries with remaining staff, the MTF will arrange for care through the civilian sector, including Department of Veterans Affairs, under existing agreements and as designated through the TRICARE Regional Directors for their respective regions, and through the expansion of the hours worked by the remaining staff (usually 60 hour work weeks). While voluntary ARC support may be utilized, involuntary ARC mobilization should be used only as a last resort, paying close attention to current HQ USAF/XO and SG requirements and policies. IAW AFI 10-802, Military *Support to Civil Authorities*, ANG forces acting under State orders (State Militia or USC Title 32 status/not in Federal Service), have primary responsibility for providing military assistance to State and local government agencies in civil emergencies.

3.2. Concept of Operations.

3.2.1. Joint Forces Command's Integrated CONUS Medical Operations Plan (ICMOP) provides direction and time phasing of required augmentation forces to support CONUS-wide health services. Medical planners at all levels will use the ICMOP as a source document when developing supporting plans.

3.2.2. As identified in the ICMOP and programmed in the Medical Resource Letter (MRL), ARC unit personnel will provide expansion/reconstitution for medical facilities designated in the MRL for reconstitution. Other facilities not identified in the MRL for reconstitution will have to depend on the ARC personnel on the FFGK1 and FFDAE UTCs as a manpower pool.

3.2.3. AE Units will provide CONUS casualty redistribution in support of the ICMOP as directed by the United States Transportation Command (USTRANSCOM) and Tanker Airlift Control Center (TACC).

3.2.4. Individual Mobilization Augmentees (IMA) and Pre-trained Individual Manpower (PIM), consisting of the Individual Ready Reserve, Retired Reserve, Standby Reserve, and Retired Regular, will be utilized as needed.

3.2.4.1. Air Force wartime requirements are the basis of medical IMA Ready Reserve authorizations. Assignments in the IMA program are authorized as positions managed by HQ ARPC/SG, Denver CO with training attachments located at various active duty Air Force units.

3.2.4.2. In peacetime, medical IMAs complete medical readiness and peacetime mission support training at their attached/assigned active duty unit.

3.2.4.3. During wartime, humanitarian assistance, and disaster response contingency missions, CONUS MTFs employ medical IMAs as replacements for MTF personnel who have deployed. IMAs will mobilize as directed by AFRC/CC. Although they can deploy, medical IMAs normally are not assigned to a specific deployment position.

3.2.5. Each MTF or unit designated to receive personnel reconstitution will include information in the MCRP/EMP that outlines reception, training, and support requirements for these personnel. The medical unit will develop the MCRP/EMP as directed in **Chapter 4**. The ARC will incorporate the contingency plan into the Unit Mission Briefing.

3.3. Affiliated Organizations for CONUS Medical Support.

3.3.1. Department of Veterans Affairs (VA). The VA health care system is the primary backup to the DoD in time of war or national emergency. The VA and DoD must jointly plan and establish procedures to implement contingency operations. Air Force MTFs identify wartime medical support requirements and areas where they may need VA support. Specifically, they identify any requirements that may be beyond the MTF capability and then inform the nearest VA medical facility. The designated VA facility and MTF jointly plan for using available VA resources during wartime or emergency situations. Local plans and agreements and MOU/MOA document VA support. MAJCOMs should review plans annually, including MOU/MOAs.

3.3.2. The National Disaster Medical System (NDMS). The NDMS is an integrated Federal, State, local and private sector medical response system for medical support during wartime or major United States domestic disasters. NDMS provides DoD with medical care resources from the civilian sector to backup the VA and DoD medical contingency arrangement.

3.3.2.1. Specific Air Force MTFs are designated as NDMS Federal Coordinating Centers (FCC). They will:

3.3.2.1.1. Develop, maintain, and exercise an NDMS operations and patient reception plan for the assigned area in conjunction with other Federal, State and local agencies, offices of emergency services, media, and other agencies, as required. If designated on the MRL, Military Patient Administration Teams (MPAT) should be designated as MCRP disaster response teams. All MCRP team training and exercise requirements apply. In addition, each exercise will include a review of local procedures for MPAT and verify supporting military unit MPATs are staffed and trained, as applicable.

3.3.2.1.2. Establish and maintain MOUs/MOAs on approved Federal Emergency Management Agency (FEMA) form with local hospitals for participation in NDMS, as well as with those providing support as detailed in the MCRP. MOUs/MOAs identify the types of support and the conditions under which that support becomes available and will be revalidated with each facility annually.

3.3.2.1.3. Attend State, county, and regional conferences concerning NDMS issues when funding available. Participate whenever possible in continuing education programs with State, county, and community offices of emergency services and other health care organizations.

3.3.2.1.4. Plan and implement at least one annual NDMS area exercise. Accomplish planning with all participating facilities to encourage maximum participation and ensure the existing plan is tested to the fullest possible extent. After-action reports will be forwarded to MAJCOM/SGX.

3.3.2.1.5. Identify NDMS resource requirements, to include training and exercises, through the existing MTF budget process.

3.3.2.1.6. Provide the MAJCOM/SGX NDMS representative with the name, rank, address, office symbol, duty title, Defense Switched Network (DSN) telephone number, e-mail address, commercial telephone and FAX numbers of the individual POC assigned to units that have FCC responsibilities. Provide an information copy to HQ USAF/SGXO.

3.3.2.1.7. Report minimum and maximum bed numbers for each NDMS participating hospital as required by HQ USAF/SGXO and HQ USTRANSCOM. Request of bed information is licensed under Report Control Symbol (RCS): HAF-SGX(AR)8602, Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C). During emergency situations, the report is designated emergency status and precedence code C-1, Continue under emergency conditions, Priority. Transmit during MINIMIZE, when necessary.

Chapter 4

MEDICAL UNIT PLANNING PROCESS

4.1. Planning Responsibilities.

4.1.1. Air Force Medical Service (AFMS). The AFMS is responsible for organizing, training and equipping the medical support forces necessary to sustain maximum mission capability and effectiveness. The medical planning process must encompass all aspects of medical support for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies.

4.1.2. MAJCOM/Air Component Planning Process:

4.1.2.1. Planning. MAJCOM medical planners provide guidance to medical support personnel operating at base level on all aspects of medical readiness planning and training, as well as provide medical readiness functional expertise to the command leadership. The primary focus is the timely provision of medical personnel prepared to respond to any wartime, humanitarian assistance, homeland security/defense, or disaster response contingencies. This is done through the management and oversight of unit medical readiness programs (personnel and materiel). Key roles include, but are not limited to, UTC and WRM allocation, SORTS DOC statement (AF Form 723) issuance, exercise planning, and manning the Crisis Action Team (CAT)/Battle Staff/Contingency Support Staff (CSS).

4.1.2.1.1. (Added-PACAF) PACAF/SGX staff has a deliberate medical planner, who is responsible for developing health service medical support plans for US Pacific Command (PACOM) OPLANs/CONPLANs. Medical planning ensures theater Health Services Support (HSS) is adequate, which includes the systematic examination of all factors based on the health threat, medical intelligence, anticipated number of casualties, duration of the operation, the theater patient movement policy, available lift, hospitalization, sustainment, etc. The deliberate medical planner is the single point of contact for PACAF/XP (Contingency Plans and Policies Division), PACOM, and theater components (Marine Forces Pacific, US Army Pacific, Pacific Fleet, and Special Operations Command, Pacific) deliberate planning activities.

4.1.2.2. Training. Staff training opportunities include: Armed Forces Medical Intelligence Center (AFMIC) Introduction to Medical Intelligence Course, Contingency Wartime Planners Course (CWPC), Global Command and Control System (GCCS), Joint Operation Planning and Execution System (JOPES), Joint Medical Planner's Course (JMPC) Basic, JMPC Advanced, National Inter-Agency Civil-Military Institute (NICI), Area Of Responsibility (AOR) Specific Orientation Courses and appropriate continuing education.

4.1.3. Base-level Planning Process:

4.1.3.1. Planning. Base-level planners assess the medical unit's capabilities to support wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies. Assessment of proper response is developed and implemented through publication of the MCRP/EMP and input to the Base Support Plan, Disaster Preparedness and other plans as required by the Wing Plans Offices.

4.1.3.1.1. (Added-PACAF) Unit-level medical readiness personnel, in conjunction with a NAF, lead wing or MAJCOM representative, will provide input to Part I and Part II of the Base Support Plan (BSP).

4.1.3.1.2. (Added-PACAF) Notify PACAF/SGX as soon as possible when a BSP site survey is scheduled for the Wing/Base of assignment, along with the message of announcement, if available. PACAF/SGX will make sure the medical unit associated with the "Lead" wing is in fact the appropriate unit to conduct the medical portion of the BSP. If not, PACAF/SGX will coordinate with the BSP conference POC to identify appropriate medical personnel/unit to conduct the assessment.

4.1.3.1.3. (Added-PACAF) Upon completion of BSP, forward copies to PACAF/SGX of Part I to **mailto:pacaf.sgx@hickam.af.mil** and Part II to **mailto:pacaf.sgx@dms.hickam.af.smil.mil**

4.1.3.2. Training. AF Medical Readiness Planner's Course is required for the MRO/MRNCO/MRM, as identified in paragraph **1.6.5.** Other training includes SORTS, MRDSS, Base/Wing specific training and Disaster Preparedness, as needed. Specific unit mission requirements may include attendance of the CWPC or JMPC. Continuing education may include the Medical Readiness Planners Symposium (J5OZO4000-005) and other civilian courses.

4.1.3.2.1. (Added-PACAF) PACAF MRO/NCOs will plan and budget for the professional growth of MR staff members maximizing use of all training opportunities to ensure the currency of information and quality of information being provided to MR customers.

4.1.3.2.2. (Added-PACAF) Opportunities include, but are not limited to:

4.1.3.2.2.1. (Added-PACAF) Annual PACAF Medical Readiness Workshop, Hickam AFB, Hawaii, 4 days.

4.1.3.2.2.2. (Added-PACAF) Medical Readiness Planner's Symposium. PACAF/SGX will request two AETC funded quotas per medical unit, therefore, if more than two personnel can attend the symposium from a particular unit, funding for individuals above two must be funded by the unit. If additional funded quotas exist, it is possible more than two funded quotas can be given to a unit.

4.1.3.2.2.3. (Added-PACAF) Rookie Day is held in conjunction with the Medical Readiness Symposium for MRO/MRNCO/MRMs assigned to readiness for less than one year; cost includes per diem for only one day as the travel is covered under an AETC funded quota for the Symposium.

4.1.3.2.2.4. (Added-PACAF) DoD Emergency Preparedness Courses.

4.1.3.2.2.5. (Added-PACAF) Air Force Inspection Agency Health Services Inspection Observer at PACAF MTF that is similar to unit of assignment, i.e. bedded MTF vs. outpatient clinic.

4.1.3.3. MOU/MOA. Coordinate in writing with all civilian/non-federal agencies, and DoD/federal agencies, both on-base and off-base, agreeing to support the MTF. The MOU/MOA should state all specific details associated with the agreement, for example, the number of beds, types of specialties, levels of care, transport support, and reimbursement methods (if any), especially when working with civilian health care providers. Since various disasters call for different levels of sup-

port, incorporate as much detail as possible. Do not duplicate healthcare support services provided under the Managed Care Support Contracts, which are to be addressed in the MCRP Annex W, TRICARE.

4.1.3.3.1. (Added-PACAF) PACAF medical readiness offices will forward copies of all MOUs/MOAs developed in support of their MCRP and BSPs to PACAF/SGX.

4.2. Medical Contingency Response Plan (MCRP) and Emergency Management Plan (EMP). The MCRP/EMP establishes procedures for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies as well as provides medical policy and local procedures for the BSP. (MCRP format is in **Attachment 2**). All MTFs (including deployed medical units) will develop a MCRP that describes medical responses to the predetermined contingency scenarios listed in **Attachment 2**. AFRC units not co-located with an AC MTF will describe their disaster response in applicable base plans. AFRC generation medical units follow higher headquarters guidance upon mobilization. ANG medical units will follow wing, state and higher headquarters guidance when applicable. Non-MTF AC and AFRC medical units co-located with an AC MTF are listed as manpower resources within the local MTF's MCRP when present for duty. MTFs can identify and train co-located medical unit personnel to augment specific MCRP teams.

4.2.1. Using AFMAN 10-401V2, *Planning Formats and Guidance*, Enclosure D, as an example, format the MCRP addressing the following parts: cover page, letter of transmittal, security instructions, record of changes, plan summary, basic plan, annexes and distribution list. All annexes outlined in **Attachment 2** must be addressed. If a particular annex does not apply, annotation must be made in the annex as "Not Applicable". Any annex deemed not applicable must also be addressed in the MRSF minutes stating the justification for this decision. Compliance with the format, as prescribed, will be instituted with the next MCRP complete rewrite.

4.2.2. Responsibilities, missions and tasks will be included in the plan. Reference the BSP and include base operations support not outlined in the BSP.

4.2.3. If an off-base or non-military agency is identified in the MCRP/EMP to provide any degree of support, a MOU/MOA must be established, as described in paragraph **4.1.3.3.**, and a copy maintained by the MR office. For on-base agencies, coordinate the MCRP/EMP with the supporting entity using as AF Form 1768, **Staff Summary Sheet (SSS).** Clearly outline what support is required.

4.2.4. The MCRP/EMP will be reviewed by the MRSF/EMC annually. Documentation of the review will be maintained in the medical readiness office. Minor changes to the MCRP/EMP may be pen and ink, not requiring complete rewrite. Minor changes must be coordinated by the applicable agencies. Once coordinated, the changes will be approved by the MRSF/EMC, but do not require MAJCOM review. All changes will be reviewed by the MRSF and must include the date of the original plan. The MCRP will be rewritten every three years or when the number of changes is significant (35% of the document). The EMP will be rewritten based on State requirements.

4.2.4.1. (Added-PACAF) PACAF MTFs are required to rewrite the MCRP every two years or when 35% of the document has changed.

4.2.5. Submit the MCRP/EMP rewrites to the MAJCOM for review prior to publication and after full coordination with applicable agencies. Plan reviews will be accomplished by MAJCOMs within 60 days. Concurrence is implied, if no response from the MAJCOM is received within that time period.

4.2.5.1. (Added-PACAF) PACAF MTFs will submit their MCRP to the PACAF SGX office in a single WORD DOC format ensuring all Chapters and Annexes are compiled into a single document. After which it will be zipped and emailed to the PACAF SGX office.

4.2.5.2. (Added-PACAF) PACAF MTFs will submit MCRP/EMP rewrites and annual reviews to PACAF/SGX for review before the unit publishes the document, no matter how much or little the document has changed.

4.2.5.3. (Added-PACAF) PACAF MTFs will not assume concurrence if no response is received from PACAF/SG within 60 days after receipt. The Medical Readiness staff will contact PACAF/SGX at or beyond the 60-day mark for a status of the MAJCOM review**.** If the 60-day MAJCOM review suspense was exceeded, PACAF/SGX will provide the MTF a written response.

4.3. Maintenance and Distribution of the MCRP and Supporting Checklists. The MR office will manage the preparation, coordination and publication of the MCRP. Distribution of this information will occur as follows: (Not applicable to ARC.)

4.3.1. Distribute copies of the MCRP and all supporting checklists to the following individuals or organizations:

4.3.1.1. The medical unit commander and deputy commander.

4.3.1.2. The MR office including additional copies for transfer to the shelter, alternate medical facility, SRC and deployment location, as applicable.

4.3.1.3. Medical Control Center (MCC).

4.3.1.4. Disaster team chiefs. Team chiefs will review and, if necessary update their respective annexes and checklists at least once a year.

4.3.1.5. Parent MAJCOM.

4.3.1.6. Contributing organizations or units (including ARC) listed in the plan.

4.3.1.7. Base CE Readiness Flight.

4.3.1.8. Wing plans office.

4.3.1.9. Battle Staff/CAT.

4.3.1.10. Medical EET Chief.

4.3.2. Each medical unit tasked to support an OPLAN or augment an overseas unit may request a copy of the deployed location MCRP.

4.3.3. Maintain master checklist set for distribution with the MCRP.

Chapter 5

INITIAL AND SUSTAINMENT TRAINING

5.1. Purpose and Objective. Emerging national and military strategies in support of wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies are the driving forces behind the training requirements to provide initial and sustainment training for all AFMS personnel.

5.1.1. All medical readiness training requirements are divided into four categories; Core, Deployment, Field and JIT. The frequency of the training requirements in each category is identified in the Medical Unit Readiness Training (MURT) Matrix **Attachment 3**.

5.1.1.1. Core Requirements: All AFMS personnel, with a fully qualified medical AFSC, must complete within six months of being assigned to a unit or as AEF requirements dictate. Currency will be maintained as required by **Attachment 3**. This also includes all medical personnel assigned to deployable UTCs in non-medical units such as the SMEs and IDMTs. For ARC, the six months begin after Basic Military Training (BMT) or the AFSC awarding technical school.

5.1.1.1.1. (Added-PACAF) Medical readiness training is synonymous with Medical Unit Readiness Training (MURT), formerly known as Continuing Medical Readiness Training (CMRT) and encompasses training listed in **Attachment 3**, AFI 41-106. All PACAF medical personnel, regardless of assignment to a standard UTC, (FFEP1, FFGL2, FFGKN, etc.), or an Associate (A)-UTC, (FFDZZ, FFEZZ, FFHZZ etc.), are required to complete all nine core training requirements listed in **Attachment 3**, AFI 41-106, pages 55-56. Due to the nature of overseas assignments, the requirement for timely accomplishment of training is imperative. More stringent completion requirements are listed below: Refer to **Attachment 16 (Added)** for PACAF AFWUS coded UTC information.

5.1.1.1.1.1. (Added-PACAF) Personnel assigned to an Associate-UTC with an AFWUS code beginning with “A” will complete RSV training based on their duty AFSC.

5.1.1.1.1.2. (Added-PACAF) Personnel assigned to a Standard UTC with an AFWUS code beginning with “D” must complete RSV training for the AFSC of the UTC position they are filling. Individuals will train to the capability of the Mission Capability Statement (MISCAP) for their assigned UTC.

5.1.1.1.1.3. (Added-PACAF) Medical personnel assigned to short tour duty locations (Osan, Kunsan and Andersen) will complete training in the Core requirements as part of their in processing events, or not later than 2 months after arriving on base.

5.1.1.1.1.4. (Added-PACAF) Medical personnel assigned to “other than” short-tour locations will accomplish all core training requirements within 4 months of arrival to duty station.

5.1.1.1.1.5. (Added-PACAF) Frequency of core training requirement after initial training at new duty location will follow guidelines in **Attachment 3, AFI 41-106**. Units with “D” or “A” AFWUS coded UTCs assigned to an AEF Bucket, i.e. AEF01, AEF05, will align core training with AEF cycle timeline. Training must be completed NLT 60 days prior to their on-call period. For short-tour locations, (Osan, Kunsan and Andersen) only the initial training is required due to tour-length. If personnel extend beyond original assignment, repeat/refresher of core training is required.

5.1.1.1.1.6. (Added-PACAF) Units with deployable UTCs postured as an Enabler (E-ROK or E-PAC) will use the A-UTC postured AEF bucket to establish training schedules.

5.1.1.2. Deployment Requirements: Established by agencies outside of the AFMS in order to deploy to a theater of operation, e.g., Combat Arms training, NBC Defense, Explosive Ordinance Reconnaissance (EOR), and Deployment Process, and are accomplished IAW **Attachment 3**. ***NOTE***: Wing/Base disaster preparedness office (CEX) has primary responsibility for NBC Defense training.

5.1.1.3. Field Requirements: Are ideally suited for instruction in a field environment and accomplished IAW **Attachment 3**, e.g., shelter assembly, low-light operations. AFRC UTCs assigned a reconstitution/expansion mission are allowed to do hospital training with the attached MTF in lieu of field training. The following AFRC UTCs do not require field training: FFGK1, FFDAE, and FFGAA. All other UTCs within the ANG, AFRC and AC are subject to field training.

5.1.1.4. JIT Requirements: Completed just-in-time or with short notice based on an actual deployment location.

5.1.2. Enlisted personnel receive initial medical readiness training, through the Expeditionary Medical Readiness Course (EMRC) at Sheppard AFB or Basic Expeditionary Medical Readiness Training (BEMRT) at Brooks AFB, in conjunction with their AFSC-awarding courses. Officers receive initial training by attending the Commissioned Officer Training (COT)/Reserve Commissioned Officer Training (RCOT) course, or through a commissioning program such as a service academy, Reserve Officer Training Course (ROTC) or Officer Training School (OTS). All personnel that do not receive medical readiness training through these accession programs must be trained at the unit level within six months of their assignment IAW **Attachment 3**. In the ARC, the six-month window begins upon their return from BMT or the AFSC-awarding technical school.

5.1.2.1. Initial training will include all components of core (excluding Unit Mission Brief, AFSC-specific and MCRP/EMP training), deployment (excluding Combat Arms and UTC training) field, and just-in-time training identified in **Attachment 3**.

5.1.3. Interns, residents, and personnel in fellowship training status who are assigned to a deployable UTC must complete MURT IAW paragraph **5.1.1.** and it's subparagraphs.

5.1.4. Students enrolled in the Health Professions Scholarship Program must participate in MURT, when available, during their 45-day annual tour of duty at an Air Force MTF. This includes participating with other medical unit personnel in MURT and exercises scheduled during their tour as their duty schedule permits.

5.1.5. MURT is recommended for all chaplain service personnel assigned to a MTF or to a chaplain readiness team with a deployment tasking. The base senior chaplain ensures that the chaplain readiness officer coordinates with the medical unit MRO/MRNCO/MRM to arrange for chaplain service personnel to participate in MURT. MAJCOMs and Field Operating Agencies may provide additional guidelines.

5.1.6. SME/Geographically Separated Unit (GSU) medical personnel and non-medical personnel assigned to medical elements will complete the requirements in this chapter as well as specialized training in support of unique medical missions. ***NOTE***: If these personnel are not assigned to a deployable UTC, JIT standards will apply. The host medical unit will monitor the MURT status of all

medical personnel assigned to their base, and non-medical personnel assigned to their medical UTCs, e.g., communications and CE personnel assigned to Aeromedical Evacuation (AE) UTCs. The MURT status of medical personnel assigned to non-medical UTCs will be forwarded monthly to the unit's MAJCOM (the training is applicable to ARC, but the reporting is not). AFRC will monitor status through periodic WBITS review.

5.1.6.1. Higher headquarters/MAJCOMs will complete the requirements in this chapter, and as specified in **Attachment 3**. A unit readiness training monitor will be appointed for the purposes of tracking unit staff training.

5.1.6.2. (Added-PACAF) PACAF Host Medical Treatment Facilities (HMTFs) for IDMTs assigned to geographically separated units (GSU) or collocated operating bases (COB) will establish a training program to ensure Independent Duty Medical Technicians (IDMT) accomplish all of the 4N0XX RSVs within their initial orientation/in processing program prior to arrival at their remote duty location. IDMTs are also required to accomplish core training requirements (minus MCRP/EMP) and must be completed within 1 month of arrival.

5.1.6.2.1. (Added-PACAF) If an IDMT extends beyond their initial short-tour assignment, they must re-accomplish the core training requirements (minus MCRP/EMP) to meet frequency requirement in **Attachment 3**, **Table A3.1.** AFI 41-106.

5.1.6.3. (Added-PACAF) Medical personnel assigned to COBs are assigned to A-UTCs in AFWUS. PACAF Medical Units with authorized/assigned (on the unit's UMD/UMPR) personnel that live/work at GSU/COBs, for example: medical logistics personnel assigned to 51 MDG/Osan AB and 8MDG/Kunsan AB, yet live and work at Taegu and Kwang Ju respectively, will ensure completion of core training requirements (minus MCRP/EMP) within 1 month of assignment. If individuals extend beyond initial short tour assignment, they must re-accomplish core training requirements (minus MCRP/EMP) to meet frequency requirement in **Attachment 3**, **Table A3.1.**, AFI 41-106.

5.1.7. Non-medical personnel (non 4XXXX AFSC) assigned to a deployable medical UTC will satisfy all of the applicable requirements described in this instruction.

5.1.8. Computer-based training (CBT) may be utilized to deliver knowledge-based MURT training. Mechanisms to ensure information is assimilated, such as post-tests, will be instituted when using CBT.

5.2. AFSC-specific Sustainment Training. AFSC sustainment training (Readiness Skills Verification Program (RSVP)) is designed to ensure all members with a fully qualified AFSC maintain adequate skills to perform their duties in a deployed/employed setting. All personnel assigned to deployable UTCs must participate in appropriate AFSC-specific training. MAJCOMs may provide supplemental guidance for all other medical personnel (non-deployable UTCs, in-place/generation/forward deployed units, CONUS reception/expansion, and those not assigned to UTCs) to complete AFSC-specific training as based on readiness missions. Enlisted personnel enter into the sustainment training upon award of the 5-skill level. Officers enter sustainment training after completion of unit orientation program and completion of a fully qualified AFSC. If the unit commander decides to assign a member to a UTC prior to attaining their fully qualified AFSC (5-level or fully qualified for officer), they must be trained on RSVP tasks as if they were fully qualified. The RSVP training database, maintained by the HQ USAF/SGXT (WAR-MED PSO), is the primary guide for AFSC-specific medical readiness training. Specific skill set requirements are devel-

oped by the appropriate Career Field Manager or SG Consultant. Units will use AFSC-specific training RSVP requirements as part of their annual medical readiness training plan to ensure that every opportunity to conduct training is identified, planned, and documented appropriately. Training tasks, which are identified in the RSVP database, are the catalyst for training program development (the database can be found by selecting SGXT from the organizational chart at the following website **https://www.afms.mil/sgx/**). (AFRC units will train to the AFSC-specific training requirements identified in WBITS.)

5.2.1. The medical unit commander will appoint, in writing, a functional training manager as office of primary responsibility (OPR) for each AFSC assigned to the unit. These individuals will have the following responsibilities:

5.2.1.1. Must coordinate with unit medical readiness and education and training office staff to determine an appropriate training methodology and timeline for completion of AFSC-specific training. ***NOTE***: ANG: functional training managers are only required to coordinate with the education and training office. The MRO is not expected to be involved with AFSC-specific sustainment training.

5.2.1.2. Review training requirements for their respective AFSC utilizing the RSVP database.

5.2.1.3. Identify AFSC-specific sustainment skills that are satisfied during daily practice, routine in-services, exercises, etc.

5.2.1.3.1. Maintain a continuity folder on the AFSC training program that records, at a minimum, who receives training, what training has been completed, when it was completed (all must be verifiable), and what training elements could not be trained within unit capabilities/ resources. Locally generated automated tracking systems are acceptable alternatives to continuity folders. AFRC will utilize WBITS to track this information.

5.2.1.4. Provide the MRSF/EMC with a written report of those skills that cannot be accomplished by the unit. The report will include reasons this training cannot be accomplished and will be attached to the MRSF/EMC minutes.

5.2.1.5. Document training on an AF Form 1098, **Special Task Certification and Recurring Training** (may use equivalent automated resources when available), and maintain in the appropriate individual training record, e.g., the Career Field Education and Training Plan for enlisted and training folder for officers. Individual training reports should be provided to members upon permanent change of station or deployments.

5.2.2. Combine training events as much as possible in order to satisfy the elements required by this instruction and other directives.

5.3. Field Training. All personnel assigned to deployable UTCs will complete field training. This training will be conducted over two days in the field, to include the principles of low-light operations. Training will include, at a minimum, the items identified under the field requirements category of the MURT Matrix, **Attachment 3**. See **Attachment 6** for a sample field-training schedule. Safety should not be jeopardized in any phase (pre-deployment, trans-deployment, deployment and post-deployment) of field MURT. Lesson plans are available for many of these topics at the HQ USAF/SGXT (WAR-MED PSO) website (select SGXT from the organizational chart at the following website: **https://www.afms.mil/sgx/**). ***NOTE***: Emergency Medical Services will be accessible during all field training.

5.3.1. Appropriate shelter set up, field sanitation and hygiene, disease and injury prevention, and low light/black out procedures must be accomplished during field training. Field training will include a scenario-based exercise that challenges the UTC capabilities. Review of the UTC Mission Capabilities Statements (MISCAPs) and Concept of Operations (CONOPS) will aid in developing the exercise. Core and deployment training requirements can be accomplished in the field at the discretion of the medical unit commander.

5.3.2. The ARC UTC field training program is based on a stable AEF training cycle. Training will be completed at a site approved by the component (ANG or AFRC) MAJCOM/SG. Components may grant credit for participation in real world deployments and exercises for a given AEF training cycle IAW paragraph **5.6.**

5.3.3. Further guidance for annual tour (AT) training for AFRC is found in AFRCI 10-204, *Air Force Reserve Exercise and Deployment Program*. AFRC attendance at the Reserve Medical Readiness Field Training (RMRFT) site, Sheppard AFB, TX is required for the following UTC missions: Small Portable Expeditionary Aeromedical Rapid Response (SPEARR) Team, Expeditionary Medical Support (EMEDS) Basic, EMEDS +10, EMEDS +25, AFTH, and Aeromedical Staging Squadron (ASTS) increments. Other mission types may attend on a space available basis.

5.3.4. The AE unit training must focus on establishing and maintaining command, control and communications over aeromedical evacuation assets and on maintaining mission-ready crews. Training emphasizes the integration of all UTCs to create a functional AE system.

5.3.5. AE personnel, both air and non-crew members (excluding ASTS personnel who attend the formal ASTS course) must meet the following training requirements:

5.3.5.1. Active component personnel will complete the initial Aeromedical Evacuation Contingency Operations Training (AECOT) course within 12 months of assignment to an AE unit. Newly accessed non-crew ARC personnel will complete initial AECOT course within 18 months of completion of Basic Military Training/Commissioned Officer Training and AFSC formal course training. Crewmembers and ANG CCATTs will complete initial AECOT within 18 months of flight qualification for their primary mission design series (MDS) aircraft or formal CCATT Course attendance. Personnel that have never attended AECOT are required to attend within four AEF training cycles (not to exceed 60 months) from the date of this publication.

5.3.5.2. Subject Matter Experts teaching AECOT will participate in all aspects of the course and will receive course credit based on the recommendation of the AECOT course supervisor.

5.3.5.3. Completion of Theater Aeromedical Evacuation System (TAES) sustainment training (not including AFSC-specific sustainment training) is required every four AEF training cycles (not to exceed 60 months).

5.3.5.4. Initial AECOT training may be waived at the unit commander’s discretion, based on experience gained/roles played in a ground UTC during assignment to a deployed TAES, Joint Readiness Training Center (JRTC), or participation in an exercise that encompassed a fully deployed TAES. A copy of the commander's approved waiver will be forwarded to the unit's ground training or readiness office, MAJCOM/SGX and AMC/SGX. This waiver does not include the Deployment Requirements of MURT, i.e., Combat Arms or NBC Defense, etc.

5.3.5.4.1. (Added-PACAF) PACAF AE unit commanders can not approve initial AECOT training waivers; only PACAF/SGX can grant.

5.3.5.5. All Critical Care Air Transport Team (CCATT) UTCs (FFCCT, FFCCP, FFCCE, FFCCN) will attend the initial CCATT course at USAFSAM (course number B3OZYCCATT-000). Personnel may not be employed or deployed as CCATT members until they have completed the CCATT course. All CCATT personnel must also complete AECOT, IAW paragraph **5.3.5.1.** In addition, all CCATT personnel must complete sustainment training and operational support flyer status requirements, once each AEF training cycle, beginning with the cycle following the one in which they completed the CCATT course. HQ AMC determines the sustainment training and operational support flyer status requirements/frequency. Every attempt should be made to maintain team integrity while attending formal training.

5.4. SORTS T-Level Measurement Training Requirements. AFI 10-201, *Status of Resources and Training System* and supplements contain specific MAJCOM/DRU/ARC guidance on SORTS reporting. The SORTS report is an indicator of a unit's ability to accomplish its OPLAN taskings. Units that are assigned OPLAN tasked UTCs are required to initiate and complete a SORTS report on a monthly basis. Only personnel assigned to deployable UTCs are used to calculate SORTS T-Level percentages, unless directed otherwise by parent MAJCOM.

5.4.1. For SORTS reporting purposes, medical personnel tasked to deploy are considered trained if they maintain currency in all the specific portions of the MURT program as described below. Again, all portions must be complete in order to be counted as trained. See **Attachment 3** for frequency. (For AFRC generation units/UTCs (FFDAE), training requirements in **5.4.1.1.** and **5.4.1.4.**, will be used for SORTS calculations–individuals must be current in both elements to be counted as trained.)

5.4.1.1. Medical effects of NBC warfare

5.4.1.2. UTC-specific team training. Allowance standard (AS) and CONOPS review at a minimum for those units who do not possess corresponding equipment assemblages. Attendance at course B3OZYCCATT-000 is mandatory for all CCATT UTC members, as identified in paragraph **5.3.5.5.**, to be counted as SORTS trained. CCATT training waiver may be granted by AMC/SG.

5.4.1.3. Field Sanitation and Hygiene

5.4.1.4. Wound Care and Casualty Management/SABC

5.4.1.5. NBC Defense

5.4.1.6. NBC Defense Task Qualification Training (TQT)

5.4.1.7. Disease Prevention

5.4.2. Personnel who are assigned to a deployable UTC for the first time will be provided training IAW **Attachment 3**. Deployment training will be accomplished immediately upon initial UTC assignment. Field MURT will be provided at the next available opportunity. They will not be considered fully trained for SORTS purposes until all the requirements in paragraphs **5.4.1.1.** through **5.4.1.7.** are met.

5.5. Training Documentation.

5.5.1. Document MURT on any locally developed tracking form such as an AF Form 1098, **Special Task Certification and Recurring Training**, or by using an equivalent automated tracking system. AFRC units will use WBITS.

5.5.2. Maintain documentation for the current and previous AEF training cycle in order to validate training currency to include the following documents:

5.5.2.1. AF Form 522, **USAF Ground Weapons Training Data** (for deployable personnel).

5.5.2.2. AF Form 1098 or a computer generated summary of the MURT accomplished from the previous unit of assignment.

5.5.2.3. Military or civilian MURT certificates of completion.

5.5.2.4. Training waiver letters.

5.5.3. MURT documentation for credentialed providers must be recorded in the Centralized Credentials Quality Assurance System (CCQAS) IAW DoDI 1322.24, *Medical Readiness Training*.

5.5.4. Current MURT data must accompany each AFMS member upon permanent change of station or transfer to another medical unit and be presented to the medical readiness office during unit in-processing.

5.5.4.1. The Readiness Office will provide all personnel departing the unit with a letter, AF Form 1098, or computer summary indicating all training completed and, as applicable, a deployment folder. These documents will be signed by the appropriate unit medical readiness office staff to verify training completed and to provide necessary training documentation for the gaining unit.

5.6. Medical Unit Readiness Training (MURT) Equivalency Credit. Formal courses, special training events, and deployments**.**

5.6.1. Personnel may be given MURT credit for completing one or more training elements listed in the MURT Equivalency Matrix when they attend selected formal courses. See **Attachment 4**.

5.6.2. Credit can also be granted for participation in operational deployments, a major JCS exercise, or a Joint Combined or Service Exercise Training. Participation is defined as active performance of AFSC-related medical duties for the majority of the exercise or deployment. Commanders can grant personnel an AEF training cycle exemption from the field training portion of MURT if the exercise or deployment was relevant to the unit's deployment missions. Documentation must be maintained on file in the medical readiness office. Any other training that may occur during the exercise must be well documented and maintained on file.

5.6.3. The medical unit commander may request a credit for the field training portion of MURT from the MAJCOM/SG or designee, for unit personnel that actively participate in base/wing or other MAJCOM sponsored exercise such as, an ORE or ORI, or an Inspector General Exercise (IGX). The training event must satisfy the field training requirements delineated in paragraph **5.3.** of this instruction. Credit will be granted for one AEF training cycle only. Submit the request for field MURT credit waiver to the MAJCOM/SGX training POC. The request should contain the following information: 1) trainee profile (i.e., name, rank, unit designation, title, and UTC), 2) type of training accomplished, 3) method used to accomplish training (i.e., IGX, ORI, etc.), 4) justification (describe how the training requirement will be satisfied), and 5) unit POC and contact information.

5.6.4. The medical readiness office POC verifies course completion or MAJCOM credit waiver approval and documents the field MURT credit granted on the individual's training record.

5.6.5. Guidelines and specific information regarding attendance of formal courses is available through the Education and Training Course Announcements website at **https://etca.randolph.af.mil/**.

5.7. Unit Mission Briefing. The purpose of this training is to ensure unit personnel understand the roles and responsibilities of their unit's wartime, humanitarian assistance, homeland security/defense, and disaster response contingency missions. This briefing provides unit personnel with an excellent opportunity to learn about the unit's mission from a tactical and strategic perspective. By understanding the "big picture", unit personnel are better able to visualize how their participation in various activities contribute toward the unit's mission. This briefing is required for personnel upon assignment to the unit and every other AEF training cycle thereafter. Ensure unit mission briefings are included in the master MURT and exercise training plan. The unit mission brief training will include the following components:

5.7.1. Medical wartime mission. Outline the AEF concept and vulnerability window for the unit, and the wartime concept of operations as described in the unit MCRP/EMP, tasking OPLANs and appropriate BSPs.

5.7.2. The disaster response mission. Provide an overview of MCRP/EMP operations.

5.7.3. Humanitarian assistance mission. Explain the unit's potential response capability to humanitarian assistance operations.

5.7.4. Other medical missions or support. Provide an overview of any other medical missions or support required in MAJCOM or installation plans, including specific items identified in base-level programs such as the Disaster Preparedness program, the Air Base Operability Program, and the Continuity of Operations Program (COOP). (See AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*, AFI 10-212, *Air Base Operability,* AFI 10-208, *Continuity of Operations (COOP) Program,* AFI 10-802, *Military Support to Civil Authorities*, and NGR 500-1, *Military Support to Civil Authorities (MSCA)*).

NOTE: The unit mission brief will be incorporated into the unit's orientation program to educate newly assigned personnel to the medical unit regarding the information above.

5.8. MCRP/EMP and Unit Disaster Response Training.

5.8.1. Annually, each team must train IAW the team's respective annex. Each team chief will identify the training requirements and develop an annual team training plan. The annual team training plan will be submitted to the MRO for inclusion into the unit master MURT plan. The MCRP will include WMD response procedures in Annex N. (A MCRP is not required for AFRC or co-located AE units nor is the requirement to exercise it annually. However, the basic guidelines here are applicable and should be used to assist with Unit Disaster Response Training. Exercises should be incorporated to evaluate the viability of the training program).

5.8.2. Disaster response training will be driven by local base/wing requirements. MTFs should scale training requirement to meet identified vulnerabilities/threats and planned response. Medical support to wing assets will be the primary focus of the training. BSPs and the MCRP will reflect the degree of support provided by the medical unit. Training topics should be scheduled/coordinated with the unit's exercise schedule in order to better prepare members for appropriate response (training before exercising).

5.8.3. MCRP training documentation requirements are as follows:

5.8.3.1. Team chiefs will conduct, document, and track team training for both MCRP and UTC teams. Lesson plans will be maintained by the team chief and reviewed annually, prior to instruction. Copies of the team training will be sent to the medical readiness office. The format for this

documentation will include dates of training, subjects covered, attendee(s) name and instructor's signature. In addition, team chiefs will ensure make-up training is accomplished and documented for personnel who missed scheduled training.

5.8.4. ARC personnel assigned to augment AC teams must be included in the development of the MCRP team training schedule process and participate in the scheduled training activities accordingly. Designated training will be coordinated between the team chiefs, the medical readiness office and all affected reserve component personnel.

5.9. UTC-specific Team Training.

5.9.1. Units tasked with a deployable personnel UTC and its associated medical WRM assemblage must, at a minimum, set-up and inventory this material every AEF training cycle and exercise this materiel every other AEF training cycle. The exercise will include marshaling, staging and assemblage set-up (includes checking operability of all equipment, including generators, heaters, lighting systems, and appropriate fuel sources, as well as performing a complete inventory of equipment/supplies with special emphasis on dated item assessment and re-sterilization check). The exercise should be used to accomplish the annual inventories IAW AFMAN 23-110, Volume 5, Chapter 15, *USAF Supply Manual, Medical Service War Reserve Materiel (WRM) Program.*

5.9.1.1. Air Transportable Clinics (ATC) and EMEDS assemblages must be exercised once every AEF training cycle, by assigned personnel as described above. At prepositioned sites, sourced lead units are required to exercise at least one of each ATC, or EMEDS once every two AEF training cycles. At active bases, if more than one ATC, or EMEDS is maintained on a base, only one must be exercised each AEF training cycle. Other ATC/EMEDS assemblages must still be inventoried and periodic preventive maintenance performed. Forward exercise and inventory schedules to MAJCOM/SGX by 7 January each year. An After Action Report, as described in **Chapter 6**, and summary of annual inventories will be forwarded to the MAJCOM NLT 30 days after the completion of unit exercises/annual inventories.

5.9.1.2. (Added-PACAF) Deployable vs. Inplace: Deployable UTCs are standard UTCs that require the personnel and/or equipment/WRM to be prepared to deploy within DOC response times. This is apart from a theater Operation Plan (OPlan), Annex Q, which outlines how specific medical assets assigned to a medical unit will support the overall operational mission. For example, if a unit has two (2) FFLGDs, Blood Transshipment Center personnel teams, both teams must be prepared to deploy. OPlan does not relieve the unit from preparing both FFLGDs personnel UTCs for deployment. Inplace assets are those that do not move, (Blood Transshipment Center equipment package, Blood Donor Centers, Air Staging Facilities, Bed Expansion projects, etc.) These are truly "in place" assets and are maintained to operate at the home station.

5.9.1.3. (Added-PACAF) Equipment assemblages/UTCs that must be exercised by the unit once every other AEF training cycle will be listed under Section IIB on the DOC statement and the associated WRM allowance standard in Section IIIC along with the associated SORTS ESSA code for which the readiness percentage must be reported under. Equipment assets that must be exercised by the unit are those for which the unit has an associated personnel UTC assigned to the unit.

5.9.2. Units tasked with managing pre-positioned assets with no deployable personnel UTC must conduct annual inventories IAW AFMAN 23-110, Volume 5, Chapter 15 and support exercise of WRM assemblages as directed by parent MAJCOM.

5.9.2.1. (Added-PACAF) Units with pre-positioned WRM equipment for which the personnel UTCs are not assigned, **will not** exercise the asset. Units with these types of assets provide caretaker/oversight/ inventory duties. Some of these assets include pre-positioned EMEDS, Air Staging Facilities, TBTC, and Air Transportable Clinics (owned by SMEs or Red Horse), etc. The host medical unit must ensure plans are in place to ready equipment for augmenting forces. This includes coordinating base agency support for transportation, location to set up, and base operating support and other documentation in the Base Support Plans and MCRPs. The WRM equipment UTC will not be listed in Section IIB of the DOC statement, but rather only as an allowance standard in Section IIIC along with the associated SORTS ESSA code for which the readiness percentage must be reported under.

5.9.2.2. (Added-PACAF) PACAF/SGX will request exercise funds, through WARMED/EOC, to annually support an EMEDS unit to exercise pre-positioned CP-EMEDS packages on the Korean peninsula. Two planned exercises will be coordinated with 7AF/A4 medical operations officer every year, thus taking three years to complete the exercise cycle of the six pre-positioned CP-EMEDS packages. Other pre-positioned WRM assets should be exercised

5.9.2.3. (Added-PACAF) Caretaker units of prepostioned aeromedical staging facilities (ASF) and MASFs should plan to have the assets exercised once every 3 years. Units will request an ASTS or MASF unit through the OSAT process; HQ PACAF/SGX will facilitate OSAT requests. The process to request and appropriately match Reserve Forces for Overseas Annual Tours can be found in **Attachment 14 (Added)** of this instruction.

5.9.3. Units that do not possess the associated medical WRM assemblage necessary to conduct UTC-specific team training will, at a minimum, review the applicable CONOPS and the WRM AS to become familiar with the UTC operational requirements and the equipment the team is expected to utilize. However, the unit MRO is strongly encouraged to make every effort to coordinate and schedule UTC-specific team training with a unit that does possess the associated WRM assemblage. ***NOTE***: Documented evidence of real world deployment satisfies these requirements.

5.9.4. All EMEDS commanders, deputy commanders, CMOs, MDOs, and MIOs will apply for Top Secret security clearances. Appropriate security training will be coordinated with the unit security manager.

5.9.5. UTC Formal Training. At a minimum, UTC formal training (those courses with a valid course number) must be accomplished every other AEF training cycle, unless otherwise directed. Personnel assigned to UTC that have attended formal training will remain on that UTC (or one similar) for a minimum of 24 months or until they PCS. The unit commander may waive the 24-month assignment requirement. The waiver will identify why the individual was removed from the position and when the 24-month period is completed. The waiver will be maintained in the Medical Readiness Office until the end of the 24-month period.

5.10. NBC Defense and NBC Defense Task Qualification Training (TQT).

5.10.1. NBC Defense and NBC Defense TQT will be conducted IAW AFI 10-2501, *Full Spectrum Threat Response Planning and Operations*.

5.10.2. NBC Defense TQT involves the performance of AFSC-related tasks in a nuclear, biological, or chemical environment. Minimum tasks to be performed will be identified by the SG Consultants/

Career Field Managers in the RSVP/CFETP. MAJCOMs may identify additional specific tasks, standards and/or procedures for conducting this training within the command.

5.11. Combat Arms Training. AFI 36-2226, *Combat Arms Program,* and respective MAJCOM supplements govern combat arms training. Personnel identified in AFPD 16-8, *Arming of Aircrew, Mobility, and Overseas Personnel,* will complete combat arms training as required. Failure to qualify does not remove an individual from deployment or PCS assignment overseas.

5.11.1. Additional guidance includes:

5.11.1.1. Personnel currently assigned overseas are trained according to the guidelines established by the unit's MAJCOM, or as directed by the theater Combatant Commander. Personnel assigned to certain PACAF locations (such as Hawaii and Alaska) are exempt from this training as specified through HQ PACAF.

5.11.1.2. All personnel assigned to a primary deployment position must complete firearms training.

5.11.2. Weapons and qualification requirements are as follows:

5.11.2.1. Minimum weapons requirements are identified in the Combat Arms Requirements for Deploying AFMS Unit Type Codes section of this instruction (**Attachment 5**). However, the theater Combatant Commander may levy additional requirements, which is generally specified in the operation's EXORD.

5.11.2.2. At least one person assigned to each UTC must qualify for each required weapon, as outlined in **Attachment 5**. Units will coordinate with their local Combat Arms personnel for additional weapons qualifications requirements for personnel on alternate deployment UTC positions. Failure to qualify does not automatically remove an individual from deployment status. All medical personnel who qualify may be issued a weapon.

5.11.3. Document weapons training on AF Form 522, **USAF Ground Weapons Training Data**, as prescribed in AFI 36-2226, *Combat Arms Program*. AFRC units are required to document training in WBITS.

5.11.4. For fragged UTCs, units are responsible for providing weapons for their own personnel, as outlined in **Attachment 5** and IAW AFPD 16-8, *Arming of Aircrew, Mobility, and Overseas Personnel*. Weapons acquisition is not required if a base agency agrees to support the medical unit weapons requirement, as documented in a MOU/MOA.

5.12. Air Reserve Component (ARC) Training. Refer to AFMAN 36-8001, *Reserve Personnel Participation and Training Procedures*.

5.12.1. ARC units scheduled to initiate and complete their AT with an AC medical unit must provide that unit with the their annual training plan 90 days prior to AT commencement. The plan must clearly delineate the AFSC-specific sustainment training requested. The actual training provided must be negotiated well in advance and be mutually agreed upon.

5.12.2. The host AC medical unit is responsible for providing agreed upon training to the ARC unit.

5.12.2.1. Effected host AC medical unit personnel will provide ARC medical personnel with AFSC-specific (RSVP) sustainment training as outlined in the annual training plan.

5.12.2.2. Upon completion of AT, the host AC medical unit will provide the ARC unit members with a signed letter, memo, or signed computer generated report to certify that the negotiated training was actually accomplished and documented. The documentation should include the dates of training, subjects covered and personnel in attendance. ARC members who complete annual training are expected to provide the signed document to their unit training manager so that the appropriate training folders and other training tracking systems such as WBITS and CCQAS are updated in a timely fashion.

5.12.3. IMA Training Program Management.

5.12.3.1. Headquarters Air Reserve Personnel Center Command Surgeon (ARPC/SG) will:

5.12.3.1.1. Coordinate and implement HQ USAF/SG medical readiness training objectives and policies as they apply to medical IMA reservists.

5.12.3.1.2. Provide regulatory policy on medical readiness training programs.

5.12.3.1.3. Assist AC medical units who encounter problems scheduling IMA reservists for MURT.

5.12.3.2. The unit of attachment commander will:

5.12.3.2.1. Ensure that IMA reservists receive required medical readiness training.

5.12.3.2.2. Ensure IMA Reservists receive information on training requirements, the training schedule, and other required information pertaining to MURT. Provide this information to the IMA when a tasking is established in planning documents.

5.12.3.2.3. Assign an AF reserve liaison officer/NCO or civilian manager.

5.12.3.2.4. Provide recommendations related to this instruction to HQ USAF/SGX.

5.12.3.3. The unit reserve liaison officer/NCO will:

5.12.3.3.1. Ensure IMA reservists receive a minimum of 60 days notice of scheduled MURT.

5.12.3.3.2. In coordination with the MRO, monitor the program to ensure MURT is completed and appropriately documented.

5.12.3.3.3. MURT documentation will be maintained for the current and previous AEF cycle in order to validate MURT currency.

5.12.3.3.4. Notify HQ ARPC/SG of any IMA reservist who fails to comply with these training requirements.

5.12.3.4. The unit MRO will:

5.12.3.4.1. Obtain a list of attached IMAs at least annually from the unit AF reserve liaison officer.

5.12.3.4.2. Ensure all pertinent training is tracked.

5.12.3.4.3. Forward the NBC training statistics annually for all attached IMAs to ARPC/SGE.

5.12.3.4.4. Assist the AF reserve liaison officer/NCO in completing all IMA MURT documentation.

5.12.3.5. The IMA reservist will:

5.12.3.5.1. Request the annual master MURT schedule from the unit of attachment.

5.12.3.5.2. Complete scheduled training as required, or arrange for alternate training agreeable to the unit of attachment.

5.12.3.5.3. Request orders using the Web Orders Tracking System (WOTS) if attendance will be in AT or Special Tour status. HQ ARPC/SG must receive the request at least 30 days in advance of scheduled training.

5.12.3.6. IMA Exercises and Training:

5.12.3.6.1. All medical IMA reservists assigned to Category B authorized positions must complete MURT on a JIT basis prior to deployment IAW paragraph **5.1.1.4.**

5.12.3.6.2. Medical reservists in non-pay participating individual ready status are not required to complete MURT unless deployed, then on a JIT basis.

5.12.3.7. Methods of Attendance. Medical IMA reservists can complete the training requirements included in this chapter in one of the following capacities:

5.12.3.7.1. Annual Tour (AT).

5.12.3.7.2. Inactive Duty Training (IDT). IDT status can include either a pay or non-pay (retirement points only) status.

5.12.3.7.3. Special Tour-Reserve Personnel Appropriation (RPA) mandays. Request orders using the WOTS if attendance will be in Annual Training or Special Tour status. HQ ARPC/SG must receive the request at least 30 days in advance of scheduled training.

Chapter 6

ASSESSMENTS/EVALUATION AND MEDICAL REPORTING

6.1. Assessment Objective. Mission readiness is based upon how well a unit is organized, trained, and equipped. The assessment process centers on three vital steps: 1) compliance with all applicable provisions of this publication; 2) validation of data in MRDSS, ART, and SORTS; and 3) feedback from the commander, wing/base, Numbered Air Force (NAF), MAJCOM, AFIA, and Air Staff to plan for and correct identified deficiencies.

6.1.1. (Added-PACAF) MRO/MRNCO will ensure the timely update and submission of Medical Readiness Decision Support Systems (MRDSS) data, including but not limited to, annotating any significant change of readiness posture within the MTF, deployment/redeployment of personnel, percentage change in WRM projects which effect critical readiness posture, contact information for Medical Readiness or Medical Logistics staff, phone numbers, e-mail addresses, STU III numbers, 24-hour contact. Monthly updates, every 30 days, are required.

6.1.1.1. (Added-PACAF) AFMS must maintain visibility of all resources postured in support of operational requirements. This requires all unit type codes (UTC) listed in the Air Force Wide UTC Availability System (AFWUS), including A-UTCs be reported in the Medical Readiness Decision Support System (MRDSS). Units must reconcile AFWUS UTCs with DOC statements and MRDSS annually and when a new Doc statement is received.

6.1.1.2. (Added-PACAF) PACAF Medical and Aeromedical Evacuation Units will report all AFWUS "D" coded UTCs on the UTC Readiness personnel and equipment Information Page using the MRDSS Unit Input Module.

6.1.1.3. (Added-PACAF) PACAF Medical and Aeromedical Evacuation Units will report all AFWUS "D" coded Generation Missions on the Generation Missions page in the MRDSS Unit Input Module.

6.1.1.4. (Added-PACAF) PACAF Medical and Aeromedical Evacuation Units will report status of AFWUS "A" coded UTCs on the Generation Missions Page using the MRDSS Unit Input Module.

6.1.2. (Added-PACAF) Homeland Defense (HLD) Projects will be tracked in the Medical Readiness Decision Support System (MRDSS)

6.1.2.1. (Added-PACAF) HLD/HLS data must be updated using the UIM, including medical material on hand balances.

6.1.2.2. (Added-PACAF) Team Leaders are responsible for accomplishing monthly inventories of their project assets and providing the results to the Medical Readiness Flight.

6.1.2.3. (Added-PACAF) Medical Readiness personnel will make the appropriate changes to the UIM material screen when they enter their regular monthly updates to the system.

6.1.3. (Added-PACAF) Timely and accurate reporting ensures only "ready" forces are tasked. Inaccurate remarks and assessment data can potentially affect nomination decisions by the AEF Center. PACAF MTF Commanders should also ensure no unreported UTCs are reflected in the AEF Reporting Tool (ART) as they can be nominated by the AEF Center. As soon as the unit is notified of a new

UTC being added to the AEF TPFDD library and visibility in ART, the unit must access and report status of UTCs.

6.1.3.1. (Added-PACAF) PACAF MTF Commanders must review their ART UTC data for accuracy and validity. Commanders should also ensure any reported deficiencies include the number of personnel affected, AFSCs and skill level in remarks. Also, indicate any suitable substitutes for the deficient capability. Equipment deficiencies should provide the same level of detail and be consistent with SORTS remarks/GWDs.

6.2. Medical Readiness (MR) Validators. MR validators are those processes that substantiate unit effectiveness in organizing, training and equipping. Major validators include but are not limited to: MRDSS, Operational Readiness Inspections, Operational Readiness Exercises, After Action Reports, SORTS, Joint Universal Lessons Learned System (JULLS), Audits, Exercises, Functional Management Reviews, Special Management Reviews, Situation Reports, MEDRED-Cs, NATO TacEval, AFIA/SG Sustained Performance Odyssey Surveys, Air Force Remedial Action Program (RAP), Aircrew Standards and Evaluation Visit (ASEV) and SAVs. MAJCOMs and GMAJCOMs will provide primary oversight to the verification and validation of their respective unit's readiness status.

6.3. Inspector General Exercises (IGX), Operational Readiness Inspections (ORI), Operational Readiness Exercises (ORE), and NATO Tactical Evaluations (TacEval). These are performance-based evaluations of unit capability to conduct missions in a simulated contingency scenario. Generally, UTCs identified in SORTS DOC statements (AF Form 723) are tasked to deploy, employ and in most instances redeploy. Medical units without a deployment mission may still be required to provide mission support to other contingency operations. MAJCOMs, NAFs, or other higher headquarters agencies direct ORIs and IGXs. OREs are wing directed. NATO schedules TacEvals. Units should refer to MAJCOM and Wing IG documents for inspectable criteria evaluated during ORIs and OREs. All AMC units will use the Mission Essential Task Lists (METL) to assess their UTC capabilities.

6.4. Exercise Objective. Specified exercises and evaluations of unit readiness plans ensure that units can provide the required medical response for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies. Periodic exercises train medical personnel, enable them to practice documented procedures and verify medical unit readiness and also enhance cooperation with civilian hospitals and agencies.

6.5. Exercise Requirements. Medical and AE exercises will be realistic and contingency based. Medical personnel will participate in non-medical exercises required IAW AFI 32-4001, *Disaster Preparedness Planning and Operations*, DoDI 1322.24, Military *Medical Readiness Skills Training*, and other deployment guidance, i.e., AFI 10-402, *Mobilization Planning* and AFI 10-403, *Deployment Planning*, to fulfill medical exercise requirements whenever possible. Establish and assess exercise objectives using evaluators trained IAW unit/wing exercise evaluation policies and procedures. Medical exercise evaluation team representatives will participate in wing/base exercise planning to ensure medical training requirements are inserted into exercise scenarios. Scenarios should promote both AFSC and non-AFSC-specific training. Exercise scenarios involving the simulated movement of medical resources to CONUS or OCONUS locations will incorporate pre-deployment, deployment, employment, re-deployment, and post deployment phases. All operational phases do not have to occur in one exercise. When planning required exercises, units should integrate with wing activities as defined objectives and scenarios may fulfill requirements for multiple types of exercises, i.e., the Enemy Attack Exercise may incorporate a mass

casualty scenario, which meets one requirement for the MCRP exercise. Lack of wing exercises does not preclude medical exercise requirements. The sections below describe the minimum medical exercise requirements. See **Attachment 7**.

6.5.1. AFMS Involvement In A Major Field Training Exercise. DoDI 1322.24, *Medical Readiness Training*, establishes a requirement for all services to participate in an annual Joint Service exercise involving all echelons of care, to include AE and other ancillary support. AFMS participation will be determined by higher headquarters and appropriate units tasked IAW requirements identified during Joint exercise planning.

6.5.2. Required documentation shall include:

6.5.2.1. Critique Procedures. Team chiefs, medical EET members, and key players will conduct a post-exercise or incident critique (often known as a "hot wash") immediately following the exercise when practical. The MR Office will use this critique to provide cross-feed among participants, identify problems not annotated by the base EET, identify training deficiencies, and areas for improvement. Include issues discussed during the critique session in the post-exercise/incident summary.

6.5.2.2. Post-Exercise or Incident Summary. A Post-Exercise or Incident Summary Report is required for unit or base-level exercises and are submitted to the unit's MRSF/EMC for review. This comprehensive summary report focuses on unit involvement in an exercise or actual incident, and serves to document effectiveness of planning guidance, training programs, and operational responses. Following the event, units will use the summary to provide a forum for verbal and written inputs from team chiefs, EET members, and other observers. The MR Office consolidates inputs in the comprehensive summary report and uses it to brief the MRSF. This report should include the following information, as applicable:

6.5.2.2.1. Participants

6.5.2.2.2. Scenario

6.5.2.2.3. Number and types of casualties

6.5.2.2.4. Objectives

6.5.2.2.5. Achievement of objectives

6.5.2.2.6. Identification of deficiencies

6.5.2.2.7. Observations

6.5.2.2.8. Recommended corrective actions for MRSF/EMC review

6.5.2.2.9. Recommended changes to base and medical unit plans and checklists for MRSF/EMC review

6.5.3. Summary Report Review. Post-exercise or incident summary reports will be reviewed by the MRSF and attached to the minutes. Identified areas of concern are discussed by the MRSF and assigned OPRs to develop corrective action plans with estimated completion dates. Open items for corrective action are tracked through the MRSF/EMC until resolved, tested and closed. Unit commanders, through the MRSF or EMC, will elevate corrective actions that go beyond unit capabilities. The MRSF will review and approve any recommended changes in local plans or any specific corrective actions.

6.6. Readiness Exercises.

6.6.1. MCRP/EMP exercise: (Not applicable to AFRC, or to active and reserve AE units)

6.6.1.1. Medical participation in wing/base exercises will be scenario dependent. Specific exercises may not require the participation of all personnel assigned to the medical unit at once. Determination of the extent of resources required to respond shall be made at the MCC or its equivalent.

6.6.1.2. All MCRP annexes shall be exercised at least annually. When possible, exercises should be coordinated and executed to assess mutual support arrangements.

6.6.1.2.1. Units can choose to exercise portions of the wartime mission separately, for example, blood donor center mission, as determined by the medical unit commander. Scenarios must provide practical application of didactic training and application of AFSC-specific training requirements.

6.6.2. Mass Casualty Exercise. Medical units will participate in a Mass Casualty Exercise in accordance with the Summary of Readiness Exercises. See **Attachment 7**. Medical unit participation will be consistent with the specific medical capabilities and responsibilities as specified in wing plans. Demonstrated capability will be the primary focus of exercise participation.

6.6.3. Recall Exercises. Unit commanders will develop recall procedures. Recall plans should describe the methods and procedures the unit uses to locate and call back personnel to their duty station from their local residence or other non-duty locations. Recall exercises demonstrate the ability of the medical unit to provide contingency support and shall be conducted in accordance with the wing/base exercise schedule. Personnel subject to recall will be dependent upon the event scenario. Additional recall exercises may be conducted at the medical unit commander's discretion.

6.6.4. NDMS Exercise. Air Force NDMS FCCs must conduct an annual exercise with civilian hospitals that participate in the NDMS program. Planners will ensure that exercise scenarios closely resemble wartime conditions or domestic disaster response situations. After-action reports will be forwarded to MAJCOM/SGX.

6.6.5. Deployment Processing or Exercise. Units with a deployment mission fulfill deployment program requirements in accordance with AFI 10-403, *Deployment Planning and Execution,* and applicable base deployment program procedures.

6.6.6. Pre-positioned WRM Exercise. Pre-positioned assets require patient movement item (PMI) reports along with the inventory reports.

6.7. Integration of Medical/Aeromedical Evacuation Operations into Air Base Operations.

6.7.1. Intra-theater and inter-theater interfacing. Exercise scenarios should include the intra-theater and inter-theater AE interface. Participants should be briefed on the exercise scenario, theater CONOPS, rules of engagement, and supporting base plans. The goal of the training should result in seamless patient movement through the medical infrastructure.

6.7.2. Conduct of AE operations. The primary focus should be on understanding the medical/AE CONOPS, evolution of medical/AE operational capabilities, patient preparation for evacuation, realistic and safe flight line operations, establishment of logistical support, establishment of communications, the integration of PMI, and development of base operational support (to include weapons support).

6.8. Deployed Medical Reporting. HQ USAF and respective MAJCOMs have assigned operational reporting requirements for each medical unit. HQ USAF and MAJCOMs use these reports to make operational decisions on medical support of forces during emergency operations to include operational readiness status, unit availability, and patient care activities.

6.8.1. The unit commander will ensure the MEDRED-C (RCS: HAF-SGX(AR)8602) is submitted IAW procedures outlined in AFMAN 10-206, *Operational Reporting*. Liberal use of the REMARKS section is encouraged. This is one method of ensuring the MAJCOM receives valuable data regarding unit operations in the AOR.

6.8.1.1. (Added-PACAF) Refer to **Attachment 17 (Added)** for Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C) format and instructions for PACAF Medical and Aeromedical Evacuation Units. The more information provided to the MAJCOM, the fewer requests for information from the unit will be made. Ensure proper classification is used at all time. Many exercises and deployment dates, locations are classified and therefore, any communication regarding them must be classified as well. If there is a question, ask for classification guidance before sending out an inappropriately marked report.

6.8.1.2. (Added-PACAF) PACAF Medical and Aeromedical Units will submit MEDRED-C reports, **Section-A (Status Change Section)**, to PACAF/SGX immediately, but not later than 2 hours after any of the following situations listed below: Contact PACAF/SGX when there is a question whether a MEDRED-C, Section A is required or appropriate for a particular situation. Refer to **Attachment 17 (Added)** for example of Section A.

6.8.1.2.1. (Added-PACAF) Notification of AEF deployment tasking from Wing Personnel Readiness Unit (PRU), even if only one medical person is tasked. List all UTCs and all associated AFSCs if the UTC is tailored or fragmented. EXAMPLE: UTC FFEP2 minus AFSC 47G3A and 040C0A is filled by 46N3 with Commander experience approved by Supported Commander per PACAF/SGX. Include all pertinent information regarding special reporting instructions, Just in Time training needing to be accomplished and estimated completion date, issues that may impact ability to meet the required delivery date (RDD) or Date Required Inplace (DRI), etc. Refer to Example 1, **Attachment 17 (Added).**

6.8.1.2.2. (Added-PACAF) Notification (Warning, Alert, Prepare to Deploy Order, etc.) of crisis action or wartime deployment tasking, i.e. SME and ATC package to support a deployed flying squadron or an EMEDS package to support a location damaged by a natural disaster or a unit/UTC sourced in a Time Phased Force Deployment Data (TPFDD) in preparation for a contingency deployment. Medical units are responsible for reporting the tasking of an ATC, but not the SME. That is the flying squadron's responsibility, unless the Flight Surgeon and/or medical technicians assigned to the medical unit instead of the flying squadron. Contact PACAF/SGX for assistance, if necessary.

6.8.1.2.3. (Added-PACAF) Notification of Exercise (Terminal Fury, RSO&I, UFL, Tandem Thrust, Arctic Care, or Humanitarian Missions (International Health Service (IHS), JTF-Full Accounting, etc.). Pertinent information includes, but not limited to, method unit/individual was notified of tasking (message, PRU, email from PACAF, etc.), notification date, deployment date, duration, location, AFSC(s) tasked and the AFSC(s) of personnel identified to fill the tasking (if different than the required AFSC) and any other pertinent information available.

6.8.1.2.4. (Added-PACAF) Emergency/natural disaster situations that may cause the medical facility or AE unit to terminate care/AE support or be unable to provide medical response due to natural disaster warnings, or actual natural disaster damage to medical facility. Provide all pertinent information to include the real-world disaster information, when the warnings or damage occurred, actions being planned or taken (example: all medical personnel are going home effective XXXX time/date or medical personnel are taking protective measures and will abide by wing imposed curfew, etc.) and when the situation is expected to be over and/or completed. Refer to Example 2**, Attachment 17 (Added).**

6.8.1.3. (Added-PACAF) PACAF Medical and Aeromedical Units will submit MEDRED-C reports, **Section-B (Deployment Section**) to PACAF/SGX immediately upon the actual deployment/departure of personnel, but NLT 2 hours after personnel depart from home station. This applies to all medical personnel deploying for any of the situations listed in paragraphs **6.8.1.2.1. (Added)** thru **6.8.1.2.4. (Added)** Refer to Example 3, **Attachment 17 (Added).**

6.8.1.4. (Added-PACAF) DEPLOYED PACAF Medical and AE Units/Packages/Assets will submit MEDRED-C reports, **Section-C (Employment Status and Workload Section)**, immediately, but NLT 24 hours after arrival at deployed location. If personnel are only a portion of a UTC or augmenting another unit that is the lead EMEDS or AECC, ensure that the MEDRED-C, Section C sent by the deployed medical/AE unit includes the PACAF deployed personnel's arrival status and that it is sent to PACAF/SGX by any secure means (SIPRNET email, DMS, secure fax). Any location where PACAF medical and AE personnel are deployed must have PACAF/SGX included as an addressee on the MEDRED-C or added to the electronic distribution list if sent via E-mail. Ensure deploying medical personnel understand their responsibilities to communicate their status to PACAF/SGX for visibility and accountability reasons. Refer to Example 4, **Attachment 17 (Added)**.

6.8.2. In a deployed environment, casualty reporting as outlined in AFI 36-3002, *Casualty Services*, and AFI 10-215, *Personnel Support for Contingency Operations* will be accomplished by the Personnel Support for Contingency Operations (PERSCO) team or the attached military personnel flight (MPF). Close coordination must be maintained between the mortuary affairs officer, medical service personnel, and the PERSCO team.

6.8.3. Disease and Non-Battle Injury Data (DNBI) data will be compiled and reported by the personnel filling the public health and medical administration roles. The AFFOR Surgeon will determine the report format, frequency, and distribution. Computerized data collection and analysis can be done with the Medical Surveillance Theater Program or Theater Medical Information Program (TMIP) software and/or Global Expeditionary Medical System (GEMS). Reportable events are reported IAW AFI 48-101, *Aerospace Medical Operations*.

6.9. After-Action Reports RCS: HAF-SGX(AR)7901. After Action Reports (AAR) are required for MAJCOM-level or higher exercises and are submitted to the MAJCOM for review and distribution IAW paragraph **6.9.2.** After action reports will contain sufficient detail and analysis to offer the reader an accurate account of the events to include, but not limited to, dates, persons involved, outcomes, and appropriate follow-up actions. ***NOTE*:** Prior to drafting AAR, verify classification level with the classification authority for the exercise/deployment/operation.

6.9.1. Medical treatment facilities and units, including ARC, must submit an after-action report to their respective MAJCOM/SG IAW AFI 10-204, *Readiness Exercises and After-Action Reporting*

Program after support of a contingency operation or participation in a higher headquarters/JCS sponsored exercise, or as directed by the contingency AOR JTF or higher headquarters. Contingencies include the following:

6.9.1.1. National emergency/NDMS activation

6.9.1.2. Natural disaster

6.9.1.3. Armed conflict

6.9.1.4. Deployments

6.9.1.5. Humanitarian assistance

6.9.1.6. Any other response directed by HQ USAF, JCS, or the National Command Authorities.

6.9.2. Units will use the report format identified in AFI 10-204, unless otherwise directed by higher authority, i.e., JCS directed use of JULLS. MAJCOM OPRs should also provide information copies of the report to the following organizations:

6.9.2.1. AFMIC/MA-OPS, Fort Detrick, Frederick, MD 21702-5004. E-Mail: **mailto:afmicops@afmic.detrick.army.mil**, SIPRNET: **mailto:afmicops@afmic.dia.smil.mil**

6.9.2.2. HQ USAF/SGML (AFMLO), Fort Detrick, Frederick, MD 21702-5006. (No generic e-mail or SIPRNET address available, send hard copy only)

6.9.2.3. HQ USAF/SGX, 1360 Air Force Pentagon, Washington DC 20330-9223. SIPRNET: **mailto:gregory.williams@af.pentagon.smil.mil**

6.9.2.4. (Added-PACAF) PACAF Medical Readiness Offices will use the format found in **Attachment 12 (Added)** of this instruction to complete AAR. Submit AAR to HQ PACAF/SGX via email it to **mailto:pacaf.sgx@hickam.af.mil** (UNCLASS) or **mailto:pacaf.sgx@dms.hickam.af.smil.mil** (CLASSIFIED).

6.9.2.5. (Added-PACAF) AAR must be completed and submitted to appropriate agencies NLT 60 days after redeployment or end of local exercise.

6.10. (Added-PACAF) Status of Resources and Training System (SORTS). SORTS data reported is based on the unit's Designed Operational Capability (DOC) Statement. The DOC Statement is prepared by HQ PACAF/SGX for each unit and describes the capability the unit assigned. It contains unit identification; mission tasking narrative, mission specifics and the resources to be measured in SORTS. Information in SORTS is CLASSIFIED and must be appropriately classified, secured and protected. SORTS is presented monthly to COMPACAF by the Command Surgeon or designated representative. A SORTS pre-brief is prepared and presented by the PACAF/SGX staff to the Command Surgeon 2-3 days prior to the COMPACAF briefing. It is imperative that the SORTS report accurately reflects the unit's readiness status and provides sufficient detail of deficiencies and corrective action. Refer to **Attachment 10 (Added)** when preparing the SORTS report. Any change report should be fully coordinated with the HQ PACAF/SGX staff before submission. Within 24 hours of a report being submitted to the command post, notify PACAF/SGX via e-mail or phone. Specific guidance relating to the overall management of SORTS can be found in AFI 10-201, *Status of Resources and Training System.*

6.10.1. (Added-PACAF) MTF Commander Participation. The Medical Group commander is ultimately responsible for the quality and accuracy of the SORTS report. The Commander should be fully briefed on the report before signing.

6.10.2. (Added-PACAF) Submitting Reports. If a SORTS report is required or submitted outside the normal monthly report time frame required by the Wing, the unit must (1) contact/coordinate with PACAF/SGX regarding the reason for the report, the GWD and actions needed to ensure GWD is successfully met, (2) contact PACAF/SGXO within 24-hours of the command post inputting the out-of-cycle report. Out-of-cycle reports can be requested/submitted for the following reasons: receipt of a new DOC statement, any change in rating due to deployment, change up/down in any sub-area, change in operational equipment status or whenever directed by PACAF/SGX or Wing/CC. It is the responsibility of the Medical Readiness Officer to ensure the report is comprehensive and complete. The SORTS wide print or easy read are tools available to review SORTS accuracy and will be utilized. If these products are not available, the MRO or designated individual will oversee the input of SORTS data at command post to prevent incorrect data input.

6.10.3. (Added-PACAF) Medical Logistics Partnership. Preparation of the SORTS report should be a partnership between Expeditionary Medical Operations and Medical Logistics. There may be times when the only status or condition to report will be that of War Reserve Materiel (WRM). This also means information and responsibility must cross squadrons. The entire chain of command expects a clear and concise understanding of these resources, and if necessary, when and how issues will be resolved. The SORTS briefing to the Medical Group Commander will be presented by both the MRO and the DML or their designated representatives.

6.10.4. (Added-PACAF) Get Well Date (GWD). It is critical that a realistic and conservative GWD be provided for each deficient area. A realistic GWD of 6 months is far better that a hopeful one month GWD that can not be met. When GWDs are not met, detailed explanations are expected by COMPACAF.

6.10.5. (Added-PACAF) The separate CBDRT report will be submitted concurrent with the units' primary SORTS report. The CBDRT includes an overall C-level rating, measured area level rating for the (1) NBC defense equipment and supplies which is broken down into six categories of equipment along with the status of individuals and unit's level NBC defense training and NBC TGT. Attachment 4, AFI 10-201 provides guidance as to how NBC Equipment and NBC Training will be reflected in the CBDRT report.

6.10.5.1. (Added-PACAF) NBC Training and NBC TQT shall no longer be calculated as part of the SORTS-T level but shall be reflected within the Nuclear Chemical Biological Defense Report (CBDRT) as directed in AFI 10-201 Attachment 4, page 256.

6.10.5.2. (Added-PACAF) Attachment 4, Table A4.2, AFI 10-201, identifies the chemical, biological, defense equipment categories /measured items to be reflected in the CBDRT SORTS report.

6.11. (Added-PACAF) AEF Reporting Tool (ART). Refer to AFI 10-244 and the PACAF Supplement for PACAF guidance on ART.

6.11.1. (Added-PACAF) The AEF Reporting Tool (ART) is the primary source for reporting UTC capabilities. It is used by the Air and Space Expeditionary Forces Center (AEFC) to nominate UTCs and units to fill wartime and contingency requirements based solely on the status reported by the unit in ART. The "stop light" rating is taken seriously when making this determination; green = deployable (100% of equipment/supplies, personnel and training); yellow = potentially deployable (less than 100% equipment and supplies on-hand, but can be obtained from MTF or local sources quickly); red = non-deployable; gray (not reported) = deployable.

6.11.1.1. (Added-PACAF) PACAF MTFs will prepare and submit ART reports IAW 10-244, PACAF SUP 10-244. Units must review all units' UTCs in ART monthly for any additions, deletions, or changes. The same level of detailed information in SORTS is required in ART. Ensure ratings/readiness status is consistent in both reports.

6.11.1.2. (Added-PACAF) ART is NOT a Commander's report card on readiness status. ART is the AEF Center's tool to nominate UTCs to deploy, therefore, assessments and remarks must accurately reflect the status of the UTC. Only UTCs that have 100% (no shortfalls) of personnel, equipment/supplies or training will be reported as GREEN. UTCs with less than 100% of personnel, equipment/supplies or training will be reported as YELLOW or RED, which will depend on the availability to fill those shortages. It is imperative that remarks provide a detailed description of the shortfalls and a realistic get well date.

6.11.2. (Added-PACAF) All tasked PACAF MTF UTCs are required to have a "Tasked to Deploy" assessment submitted in ART within 5 days of notification (a UTC is officially tasked upon receipt of a DRMD from the wing PRU, Ref AFI 10-244, para 4.1.3.1). Commanders should indicate if a UTC can (or cannot) meet the Theater Specific Line Remarks on the DRMD. If a UTC is unable to meet its Theater Specific Line Remarks, commanders should indicate the reason and provide any available/suitable substitutes or request a waiver from the supported Commander through PACAF/SGX.

6.12. (Added-PACAF) ART vs SORTS. ART and SORTS may seem similar, but there are significant differences. **Table 6.1.** below highlights the differences:

Table 6.1. (PACAF) AEF Reporting Tool (ART) vs Status of Resources and Training System (SORTS).

AEF Reporting Tool (ART) *vs* Status of Resources and Training System (SORTS)	
ART	SORTS
1. Air Force Only	1. Joint
2. Answers the question: Can UTC Perform MISCAP?	2. Answers the question: Can Unit Support its Wartime Mission?
3. Reports on all UTC's in AFWUS as separate UTCs	3. Reports Against DOC Statement UTCs, combined to define mission capability
4. Based on AFWUS, but data is pulled from AEF TPFDD Library	4. Based on Oplans and unit's wartime mission
5. 29-day Cycle within 24-hours of Change	5. Monthly report of within 24-hours of change
6. UTC Assessment Tool	6. Leadership (Management) Tool
7. Stoplight Chart—Red, Yellow, Green	7. Capability "C"-Ratings based on sub-area objective ratings
8. Reports on Personnel, Equipment and Supplies On-hand, and Training. Medical Units do not report on Equipment Condition, if it doesn't work, it is not available.	8. Reports on Personnel, Equipment and Supplies On-hand, and Training. Medical Units do not report on Equipment Condition, if it doesn't work, it is not available.

GEORGE P. TAYLOR, JR., Lt General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Abbreviations and Acronyms

AAR —After Action Report

AC —Active Component

ACC —Air Combat Command

AE —Aeromedical Evacuation

AECOT —Aeromedical Evacuation Contingency Operations Training

AEF —Aerospace Expeditionary Force

AETC —Air Education and Training Command

AFB —Air Force Base

AFCAT —Air Force Catalog

AFFOR —Air Force Forces

AFI —Air Force Instruction

AFIA —Air Force Inspection Agency

AFMAN —Air Force Manual

AFMC —Air Force Materiel Command

AFMIC —Armed Forces Medical Intelligence Center

AFMLO —Air Force Medical Logistics Office

AFMOA —Air Force Medical Operations Agency

AFMS —Air Force Medical Service

AFPD —Air Force Policy Directive

AFPC —Air Force Personnel Center

AFRC —Air Force Reserve Command

AFRRI —Armed Forces Radiobiology Research Institute

AFSC —Air Force Specialty Code

AFSOC —Air Force Special Operations Command

AFSPC —Air Force Space Command

AFTH —Air Force Theater Hospital

AFWUS —Air Force Worldwide UTC Availability System

AMC —Air Mobility Command

ANG —Air National Guard

ANGRC —Air National Guard Readiness Center

AOR —Area of Responsibility

ARC —Air Reserve Component (includes Air National Guard and Air Force Reserve)

ARPC —Air Reserve Personnel Center

ART —AEF UTC Reporting Tool

AS —Allowance Standard

ASEV —Aircrew Standardization Evaluation Visit

ASTS —Aeromedical Staging Squadron

AT —Annual Training

ATC —Air Transportable Clinic

BEE —Bioenvironmental Engineer

BEMRT —Basic Expeditionary Medical Readiness Training

BICEPS —Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity

BMT —Basic Military Training

BSC —Biomedical Sciences Corps

BSP —Base Support Plan

BW —Biological Warfare

C3ISR —Command, Control, Communications, Intelligence, Surveillance, and Reconnaissance

C4 —Combat Casualty Care Course

C4A —Combat Casualty Care Course for Administrators (Obsolete name, see JOMMC)

CAT —Crisis Action Team

CBRNE —Chemical, Biological Radiological, Nuclear, and High-yield Explosive

CBT —Computer Based Training

CBWDT —Chemical-Biological Warfare Defense Training

CCATT —Critical Care Air Transport Team

CCQAS —Centralized Credentials Quality Assurance System

CE —Civil Engineering

CEX —Civil Engineering Readiness Flight (Disaster Preparedness)

CME —Continuing Medical Education

CMO —Casualty Management Officer

CONOPS —Concept of Operations

CONUS —Continental United States

COOP —Continuity of Operations

COT —Commissioned Officer Training

CRT —Crisis Response Team

CRTC —Combat Readiness Training Center

CSC —Combat Stress Control

CSS —Contingency Support Staff

CW —Chemical Warfare

CWPC —Contingency War Planner's Course

DC —Dental corps

DNBI —Disease and Non-Battle Injury

DOC —Designed Operational Capability

DoD —Department of Defense

DoDI —Department of Defense Instruction

DP —Disaster Preparedness

DSN —Defense Switched Network

DRU —Direct Reporting Unit

DU —Depleted Uranium

EET —Exercise Evaluation Team

EMC —Executive Management Committee

EMEDS —Expeditionary Medical Support

EMP —Emergency Management Plan

EMRC —Expeditionary Medical Readiness Course (formerly known as BMRC)

EOC —Emergency Operations Center

EOR —Explosive Ordinance Reconnaissance

EUMD —Extended Unit Manning Document

EXORD —Execute Order

F-MURT —Field Medical Unit Readiness Training

FCC —Federal Coordinating Center

FEMA —Federal Emergency Management Agency

FSTR —Full Spectrum Threat Response

GCCS —Global Command and Control System

GEMS —Global Expeditionary Medical System

GMAJCOM —Gaining Major Command

GSU —Geographically Separated Unit

HAF —Headquarters Air Force

HAZMAT —Hazardous Material

HAZWOPER —Hazardous Waste Operations and Emergency Response

HSI —Health Services Inspection

HTA —High Threat Area

ICMOP —Integrated CONUS Medical Operations Plan

ICS —Incident Command System

IDMT —Independent Duty Medical Technician

IDT —Inactive Duty Training

IFE —In-Flight Emergency

IGX —Inspector General Exercises

IM/IT —Information Management/Information Technology

IMA —Individual Mobilization Augmentee

ISSA —Inter-Service Support Agreement

JCS —Joint Chiefs of Staff

JFCOM —Joint Forces Command

JIT —Just-In-Time

JMPC —Joint Medical Planner's Course (includes JMPC Basic and JMPC Advanced)

JOMMC —Joint Operations Medical Managers Course (Formerly known as C4A)

JOPES —Joint Operations Planning and Execution System

JRTC —Joint Readiness Training Center

JTF —Joint Task Force

JULLS —Joint Universal Lessons Learned System

LOAC —Law of Armed Conflict

LTA —Low Threat Area

MAJCOM —Major Command

MC —Medical corps

MCC —Medical Control Center

MCRP —Medical Contingency Response Plan

MDNCO —Medical Defense Non-Commissioned Officer

MDO —Medical Defense Officer

MEDRED-C —Medical Report for Emergencies, Disasters, and Contingencies

METL —Mission Essential Task List

MIO —Medical Intelligence Officer

MISCAP —Mission Capability

MOA —Memorandum of Agreement

MOOTW —Military Operations Other Than War

MOU —Memorandum of Understanding

MPAT —Military Patient Administration Team

MR —Medical Readiness

MRDSS —Medical Readiness Decision Support System

MRIC —Medical Readiness Indoctrination Course

MRL —Medical Resource Letter

MRM —Medical Readiness Manager

MRNCO —Medical Readiness Non-Commissioned Officer

MRO —Medical Readiness Officer

MRPC —Medical Readiness Planners Course

MRSF —Medical Readiness Staff Function

MSC —Medical Service Corps

MSCA —Military Support to Civil Authorities

MTA —Medium Threat Area

MTF —Medical Treatment Facility

MURT —Medical Unit Readiness Training

NAF —Numbered Air Force

NATO —North Atlantic Treaty Organization

NBC —Nuclear, Biological, and Chemical

NBCC —Nuclear, Biological, Chemical, and Conventional

NDMS —National Disaster Medical System

NGO —Non-Government Organizations

NICI —National InterAgency Civil-Military Institute

NREMT —Nationally Registered Emergency Medical Technician

OCONUS —Outside the Continental United States

OCR—Office of Collateral Responsibility

OPLAN —Operation Plan

OPR —Office of Primary Responsibility

ORE--—Operational Readiness Exercise

ORI —Operational Readiness Inspection

PACAF —Pacific Air Forces

PERSCO —Personnel Support for Contingency Operations

PHA —Preventive Health Assessment

PHO —Public Health Officer

PIC —Personal Information Card

PIM —Pre-trained Individual Manpower

PMI —Patient Movement Item

POM —Program Objective Memorandum

RAP —Remedial Action Program

RCOT —Reserve Commissioned Officer Training

RCS —Report Control Symbol

RMRFT —Reserve Medical Readiness Field Training

RSG —Regional Support Group

RSVP —Readiness Skills Verification Program

RTOC —Readiness Training Oversight Committee

SABC —Self-Aid and Buddy Care

SAV —Staff Assistance Visit

SIPRNET —Secret Internet Protocol Router Network

SME —Squadron Medical Element

SOF —Special Operations Forces

SORTS —Status of Resources and Training System

SPEARR —Small Portable Expeditionary Aeromedical Rapid Response

SRC —Survival Recovery Center

SSS —Staff Summary Sheet

TACC —Tanker Airlift Control Center

TacEval—Tactical Evaluations

TAES —Theater Aeromedical Evacuation System

TIC —Toxic Industrial Chemical

TIM —Toxic Industrial Material

TMIP —Theater Medical Information Program

TQT —Task Qualification Training

TRG —Training Group

USAFA —United States Air Force Academy

USAFE —United States Air Forces in Europe

USAFSAM —US Air Force School of Aerospace Medicine

USAMRICD—United States Army Medical Research Institute of Chemical Defense

USAMRIID —United States Army Medical Research Institute of Infectious Diseases

USTRANSCOM —United States Transportation Command

UTC —Unit Type Code

VA —Veterans Affairs

WAR-MED PSO —Wartime Medical Planning System Office

WBITS —Web Based Integrated Training System

WMD —Weapons of Mass Destruction

WOTS —Web Orders Tracking System

WRM —War Reserve Materiel

Terms

Aerospace Expeditionary Force (AEF) Cycle—The AEF construct establishes 10 AEFs, each serving 3-month deployment /on-call periods, over a 15-month cycle. The 15-month cycle includes a 10-month training period, a 2-month preparation period, a 3-month employment period, and a reconstitution period after redeployment to home base.

AEF Training Cycle—A period related to the 15-month AEF cycle. An individual's training requirements are based on the AEF they are assigned to. Each person must complete all training required based on the AEF training cycle NLT 60 days prior to their on-call period. Training required in multiples of the AEF training cycle, may be accomplished any time within the period as long as the individual does not exceed the total months of the AEF multiple before the end of their on-call period, e.g., an "every other AEF training cycle" event goes non-current after 30 months. For example, if an individual attends the EMEDS course during AEF cycle 2 he is not due for training until AEF cycle 4, unless he attended training so early in cycle 2 that he will not remain current through his deployment/on-call period. (See current AEF guidance for more details.)

Annual Training—A training period related to the calendar year. Training required on an annual basis must be accomplished every calendar year, e.g., an individual who attends an annual training event on 1 Jan 2006 is current until 31 Dec 2007.

BICEPS—An acronym for the management of Combat Stress Reactions: Brevity (usually less than 72 hours); Immediacy (as soon as symptoms are evident); Centrality of management (in a centralized Combat Stress Control (CSC) unit separate from, but proximal to, a medical unit); Expectancy (CSC unit personnel expectation that casualties will recover); Proximity (of treatment at or as near the front as possible); and Simplicity (the use of simple measures such as rest, food, hygiene and reassurance).

Clinician—See Provider.

Core requirements—Those essential training requirements without which an individual/unit would significantly degrade their ability to accomplish the AFMS mission. These requirements cannot be completed JIT. See **Attachment 3**.

Disease Prevention—Encompasses the anticipation, prediction, identification, prevention, and control of preventable diseases, illnesses, and injuries caused by exposure to biological, chemical, physical or psychological threats or stressors found at home station and during deployments.

Disaster Response—Includes response to all types of natural and man-made emergency events: acts of nature; chemical, biological, radiological, nuclear, and/or high-yield explosives (CBRNE); hazardous materials incidents; infrastructure failure; etc.

First Responder—Those units/personnel who are first on the scene when medical care is required. These individuals provide initial life saving/life sustaining care to casualties prior to the transport of the patient to the next level of care. These situations include, but are not limited to In-Flight-Emergencies (IFEs), mass casualty situations, HAZMAT response, and other emergency responses. In some cases, triage teams may be classified as first responders.

Just-In-Time Training—Training that augments core requirements and occurs in conjunction with activities in support of wartime, humanitarian assistance and disaster response missions. Training is normally time sensitive and usually limited to that period of time that immediately precedes the activity, deployment or function. See **Attachment 3**.

Medical Personnel—Personnel who support the AFMS mission and hold a 4XXXX AFSC. They may be assigned to medical or non-medical units.

Medical Unit Readiness Training (MURT)—Formerly known as "CMRT". Courses, hands-on training, and exercises designed to develop, enhance and maintain military medical skills. MURT includes didactic and field training, and disaster response training (consistent with local requirements) required to ensure healthcare personnel and units are capable of performing operational missions.

MINIMIZE—A condition wherein normal message and telephone traffic is drastically reduced in order that messages connected with an actual or simulated emergency shall not be delayed.

Non-Clinician —See Non-Provider.

Non-Provider—Those individuals who are responsible for clinically managing casualties or providing direct casualty care during operational missions. See **Attachment 8**.

Provider—Those individuals who have direct patient care responsibilities, who by virtue of their scope of practice, may be called on to clinically manage or assist casualties during a contingency, be it wartime, humanitarian assistance or disaster response. This includes those designated as "first responders" (ED and Flight Medicine Staff). For the purposes of this instruction, the terms clinician and provider will pertain to all physicians, nurses, physician assistants, and only those dentists and 4N0s used in a first response capacity. See **Attachment 8**.

Sustainment Training—Training required to maintain or enhance the proficiency of individual readiness, clinical, and unit/platform skills.

Training Cycle—That period of time, as defined by each service component, in which all mandatory medical readiness training must be completed. The Air Force training cycle coincides with the 15-month AEF cycle.

Wound and Casualty Management—Wound management refers to those medical skills that are needed to care for trauma and disease non-battle injury patient conditions. Casualty management refers to those skills that are needed to triage and regulate casualties, to include medical land and air evacuation, and staging.

Yearly Training—A 12-month training period, i.e., Yearly training must be accomplished every 12 months and is non-current after 12 months have passed since the training date. For example, an individual who attends a yearly training event on 1 Apr 2006 is current through 31 Mar 2007.

Attachment 1 (PACAF)

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

Abbreviations and Acronyms

AB—Air Base

AECC—Evacuation Control Center

AES—Aeromedical Evacuation Squadron

AEFC—Air Expeditionary Forces Center

ALCOM—Alaskan Command

AMOCC—Air Mobility Operations Control Center

BTC—Blood Transshipment Center

CFAT—Comprehensive Functional Area Training

CFC—Combined Forces Command

CONPLAN—Contingency Plan

DMS—Defense Message System

DRMD—Detailed Resource Movement Document

EOC—Exercise Oversight Committee

FDO—Flexible Deterrent Option

HSA—Health Services Administration

JMETL—Joint Mission Essential Task List

MASF—Mobile Aeromedical Staging Facility

MEFPAK—Manpower and Equipment Force Packaging System

MFEL—Manpower Force Element List

MINCO—Medical Intelligence NCO

MMBCWC—Medical Management of Biological, Chemical Warfare Casualties

NIPRNET—Non-Secure Internet Protocol Router Network

NORTHCOM—Northern Command

OSAT—Overseas Annual Training

PACOM—Pacific Command

POSC—Pacific Operations Support Center

PRU—Personnel Readiness Unit

RAT—Readiness Assessment Tool

RC—Reserve Component

RESTOPS—Restore Operations

RSO&I—Reception, Staging, Onward Movement, & Integration

TPMRC—Theater Patient Movement Response Center

TPFDD—Time Phase Forces Deployment Document

UCC—Unit Control Center

ULN—Unit Line Number

UIM—Unit Input Module

USFK—United States Forces Korea

USFJ—United States Forces Japan

Attachment 2

FORMAT FOR THE MEDICAL CONTINGENCY RESPONSE PLAN (MCRP)

A2.1. Basic Plan.

A2.1.1. References. List references and dates in seven subsections as follows:

A2.1.1.1. Air Force Policy and Guidance, e.g., AFPDs, AFIs, AFPAMs, AFMANs, etc.

A2.1.1.2. MAJCOM Policy and Guidance

A2.1.1.3. Wing Publications

A2.1.1.4. Unit Plans

A2.1.1.5. Maps, Charts, and Grid Maps (the base and surrounding area, as applicable)

A2.1.1.6. MOUs/MOAs

A2.1.1.7. Other references.

A2.1.2. Contributing Organizations. Include all units and organizations (military and civilian), which can support the medical facility. Describe the support provided by these entities and means of activating support agreements, if applicable. Any organization referenced in the plan should coordinate prior to publication. You can employ collocated ARC medical units only when they are performing unit training duty. ARC aeromedical evacuation units can provide support if it doesn't interfere with their unit flight obligations. Identify the number of personnel by AFSC and UTCs available. Ensure MOUs/MOAs are fully coordinated in writing and maintained in the medical readiness office. ***NOTE:*** It is important to understand that ANG medical and aeromedical unit personnel may already be tasked by the Incident Command System (ICS) or State Emergency Operations Center (EOC).

A2.1.3. Execution. Include at least the following paragraphs:

A2.1.3.1. Describe the conditions under which the MCRP will be executed, who directs the execution, and who executes the plan.

A2.1.3.2. Special instructions. State which parts of the plan are required reading.

A2.1.3.3. A descriptive statement for each major team and a corresponding reference annex. The descriptive statement should tell who is responsible for preparing and maintaining each annex. Indicate responsibilities for sub-teams as an appendix to the appropriate annex.

A2.1.4. Exercising the Plan. Develop a plan and specific guidance to exercise the MCRP. At a minimum, the MCRP will be exercised IAW paragraph **6.6.1.** Include the MCRP exercise into the unit's annual training plan.

A2.2. Annexes. Each annex provides definitive information as to how, where, when, and who performs a particular function. Team compositions (peacetime disaster teams and Unit Type Codes) must indicate Air Force Specialty Code (AFSC) supporting their missions. Support each annex with checklists, designed to serve as a quick reference, chronological list of actions required in any given situation. Team chiefs prepare and maintain the checklists. You need not include checklists in the MCRP, but they must be readily available to each team chief, medical control center, and emergency treatment area. List supporting checklists (by subject or title) within the applicable annex. If not published in a unit training plan, include

an abbreviated list of training requirements and where a more comprehensive listing can be found (i.e., team training binder, AFSC-specific training database, AFI 41-106 training matrix, etc.). Include the following annexes. ***NOTE***: Depending on local requirements, additional annexes not listed in this attachment may be necessary. Annotate and describe those annexes not applicable:

A2.2.1. Annex A. General Instructions**.** Include information applicable to all medical personnel, regardless of team assignment. Discuss the following:

A2.2.1.1. Recall procedures. Recalls (UTC, unit-wide, COMM-out) will be conducted IAW paragraph **6.6.3.**, and the procedure annotated in this annex.

A2.2.1.2. Space allocation.

A2.2.1.3. Triage categories and color-coding system. The Triage Officer examines all casualties and categorizes them according to a color-coded system. When using color-coding systems to represent triage categories, coordinate with local emergency response agencies to prevent confusion during actual emergencies or joint military/civilian exercises. The following CATEGORIES and colors are generally used for standardization:

A2.2.1.3.1. MINIMAL – **Green**

A2.2.1.3.2. IMMEDIATE – **Red**

A2.2.1.3.3. DELAYED – Yellow

A2.2.1.3.4. EXPECTANT – **Blue/Black**

NOTE: Civilian medical organizations do not recognize EXPECTANT as a peacetime triage category.

A2.2.1.4. A description and diagram of the patient flow within the facility (peacetime and wartime).

A2.2.1.5. Command, Control, Communications, Intelligence, Surveillance, and Reconnaissance (C3ISR). Indicate the location of the MCC and describe command and control components, communication systems, and ISR systems as applicable. List actions required to restore communications if they break down.

A2.2.1.6. Outline base mission support with clear delineation between peacetime and wartime procedures. Do not duplicate guidance contained in the Base Support Plan, but ensure vital information is readily available to applicable personnel. Consider guidance in AFI 10-802, *Military Support to Civil Authorities*.

A2.2.1.7. At a minimum, address the following: Generation mission support (medical/dental/mental health patient records screening, ensure currency of DD Form 2770, **Abbreviated Medical Record**, immunizations, BW/CW antidote instructions (issuance and proper use of), medical intelligence instructions); Battle Staff support; Disaster Control Group support.

A2.2.2. Annex B. Medical Facility Commander/Medical Control Center (MCC). Address at least those responsibilities listed in **Chapter 1** and briefly outline the chain of command to ensure continuity if the commander is unavailable during peacetime and wartime scenarios. Outline contingency operations procedures, responsibilities, and communications resources. Clearly delineate activities during peacetime and wartime contingencies. Additionally address medical reporting procedures utilizing examples.

A2.2.3. Annex C. Patient Dispersion. Address anticipated patient population in wartime and peacetime, projected changes in availability of hospital services during contingencies and the impact on patient dispersion. If routine care will not be curtailed, describe prioritization of care. Also describe aeromedical evacuation policies and guidelines, as applicable for patient dispersion. Included a description of aeromedical staging activities and communications between the Aeromedical Staging Facility, Mobile Aeromedical Staging Facility, and MTF, as applicable. Ensure MOUs/MOAs support patient dispersion.

A2.2.4. Annex D. Casualty Management (if appropriate). Describe casualty management for each respective team/work center, to include casualty flow within the facility. Facility usage, WRM inventory, maintenance and set-up should be addressed in Annex G, Medical Logistics. Include the following appendices and tabs. Annotate and describe those appendices and tabs not applicable:

A2.2.4.1. Appendix 1 - Aerospace Medicine

A2.2.4.1.1. Tab 1 - Field Treatment Team

A2.2.4.2. Appendix 2 - Clinical Teams

A2.2.4.2.1. Tab 1 - Minimal Team

A2.2.4.2.2. Tab 2 - Delayed Team

A2.2.4.2.3. Tab 3 - Immediate Team

A2.2.4.2.4. Tab 4 - Radiology Team

A2.2.4.2.5. Tab 5 - Laboratory Team

A2.2.4.2.6. Tab 6 - Pharmacy Team

A2.2.4.2.7. Tab 7 - Surgery Team

A2.2.4.2.8. Tab 8 - Nursing Services

A2.2.4.2.9. Tab 9 - Mental Health

A2.2.5. Annex E. Public Health Team. Outline support to the base and MTF in providing:

A2.2.5.1. Communicable and vector-borne disease surveillance, prevention, control, and reporting

A2.2.5.2. Field hygiene and sanitation surveillance

A2.2.5.3. Site selection consultation

A2.2.5.4. Food safety

A2.2.5.5. Medical intelligence and health threat assessment, to include NBC warfare and terrorism intelligence

A2.2.5.6. Deployment health threat education

A2.2.5.7. Pre and post deployment health screening management

A2.2.5.8. Biological agent disease surveillance and control

A2.2.5.9. Food safety and decontamination in a CBRNE environment

A2.2.5.10. Public health response in natural disasters

A2.2.5.11. Foodborne illness outbreak investigation

A2.2.5.12. Food security vulnerability assessment

A2.2.5.13. Deployment processing

A2.2.6. Annex F. Bioenvironmental Engineering (BEE) Team. Outline support to the base and MTF in providing:

A2.2.6.1. Evaluations or assessments of environmental and occupational health hazards and recommended actions for control of these hazards.

A2.2.6.2. Monitoring of base water supply to ensure potability, safety, and survivability.

A2.2.6.3. Monitoring, evaluation, and direction for control of chemical, biological, and radiological hazards.

A2.2.6.4. Assistance in selecting base and unit shelters.

A2.2.6.5. Service as a member of the Wing NBC Cell.

A2.2.6.6. Provide NBC detection guidance to the Public Health Team, as needed.

A2.2.6.7. Assistance to the CE Readiness Flight in developing an NBC detector deployment plan and conducting NBC detection.

A2.2.6.8. Health-based risk assessment advice to medical and line commanders on NBC and HAZMAT exposures.

A2.2.7. Annex G. Medical Logistics Team. Wartime planning shall include the identification of WRM management and maintenance requirements (to include BW/CW antidotes to applicable deploying forces), description of generation mission support, and defining procedures for emergency requisition of equipment and/or supplies. Peacetime planning shall outline logistics support such as procedures for emergency requisition, facility management, biomedical equipment repair/maintenance program and the following Appendices:

A2.2.7.1. Appendix 1. Address WRM inventory, set-up and maintenance, space allocation and manpower requirements.

A2.2.8. Annex H. Manpower Team. Indicate the team responsibilities in supporting the overall medical response. Address, as a minimum, patient movement, facility evacuation support, facility security, and procedures for requesting additional manpower support. This team can include medical unit personnel not directly involved in patient care, collocated ARC medical personnel present for duty, volunteer personnel, base personnel, outpatients awaiting discharge or transportation, and any other personnel available.

A2.2.9. Annex I. Crisis Response Team (CRT). Use this optional annex in addition to or in place of the “Mental Health Team,” which is normally an appendix to Annex D. The primary responsibility of the CRT is to provide mental health services to victims and families on site and within the MTF during and post-disaster. Discuss team composition (for example, mental health officers, technicians, chaplains, public affairs officer) and responsibilities.

A2.2.10. Annex J. Facilities Management Team. Describe facility management activities in ensuring: maintenance and repair support; availability of required utilities; facility security; and maintenance or

repair of communications assets. Facility security will be staffed by the manpower team (see Annex H).

A2.2.10.1. Appendix 1. Develop fire evacuation/protection plan and list associated references.

A2.2.11. Annex K. Nutritional Medicine Team. Consider this function (particularly overseas), even though food service may not be a formally authorized function.

A2.2.12. Annex L. Patient Administration Team. Outline responsibilities relevant to patient administration functions during peacetime and wartime contingencies. Do not replicate day-to-day operational functions addressed by other directives. Focus should be on activities directly related to contingency operations.

A2.2.13. Annex M. Civilian Disturbances. Discuss medical operations during a civil disturbance.

A2.2.14. Annex N. Terrorist and Weapons of Mass Destruction (WMD) Threats. Plan medical operations and procedures for response to a terrorist attack on the base and/or the MTF. Threats include chemical, biological, radiological, nuclear, and/or high-yield explosive (CBRNE). Ensure Annex N supports FSTR Plan 10-2 (previously titled Disaster Preparedness OPLAN 32-1), to ensure wing requirements are met (or similar plan). The [unit] commander and staff have a need to know applicable classified threat information – base the Annex N on local and theater (as appropriate) threat assessments. As a minimum, commanders must use the information in the most current version of the Worldwide Chemical-Biological Threat to USAF Air Bases: 1995 – 2005 (S/NF), to develop the baseline threat. The unit NBC MDO is the OPR and the NBC MCO and MIO are the office of collateral responsibility (OCR) for Annex N.

A2.2.14.1. The Annex N will be based on local threat, vulnerabilities, wing and medical mission and limiting factors, personnel and MOA/MOUs. The intent is to plan and present a credible CBRNE defense and medical response capability given existing and available resources. The plan will address, at a minimum, procedures and processes to:

A2.2.14.1.1. Recognize, sample, detect, and identify CBRNE agents and diagnose casualties

A2.2.14.1.2. Handle, identify, and/or transport clinical and/or environmental samples for suspected biological agents. Include execution of the CDC laboratory response network and/or home station execution of the rapid advanced pathogen identification system (RAPIDS).

A2.2.14.1.3. Protect the unit and personnel from CBRNE effects

A2.2.14.1.4. Conduct disease surveillance to identify covert biological warfare (BW) agent use and/or endemic disease outbreaks

A2.2.14.1.5. Triage CBRNE casualties

A2.2.14.1.6. Decontaminate casualties that present at the MTF

A2.2.14.1.7. Treat CBRNE casualties, including restriction of movement and/or quarantine of contagious patients as appropriate

A2.2.14.1.8. Obtain and disseminate at appropriate level local and theater applicable CBRNE vulnerability assessments and intelligence

A2.2.14.1.9. Identify local limiting factors affecting ability to execute Annex N

A2.2.14.1.10. Reference and link to FSTR Plan 10-2 and other applicable deliberate plans

A2.2.14.2. The USAF WMD 1st Responder Pilot Program AFMS WMD Equipment List (available at **https://www.afms.mil/sgx/**) identifies medical WMD first response materiel applicable to many CBRNE events.

A2.2.14.2.1. These lists are guidelines and are based on planning assumptions of 300 NBC casualties and/or 100 explosive trauma casualties – non-pilot program bases may use the list for planning and programming.

A2.2.14.2.2. Pilot program bases are funded in FY02-05; other bases should program (in PE 28038f through MAJCOM) based on local threats, mission capabilities and wing requirements. Non-pilot program bases may use local funding to meet materiel and training gaps.

A2.2.14.3. If decontamination of incident casualties or first responders is required, it is a line responsibility to plan and equip to do so at the scene with designated non-medical personnel (ref AF/IL MSG DTG 231500Z APR 99, Weapons of Mass Destruction (WMD) Threat Response For US Air Force Installations, paragraph 4A(1)(D)). Every effort must be made to control and decontaminate at the scene. Medical treatment facilities which will treat incident casualties should plan, equip and train to decontaminate those who flee the scene and self-present at the MTF. See paragraph 1.7.9.1.

A2.2.14.4. The Annex N should identify processes and procedures for early recognition of covert biological agent use through disease surveillance. The Public Health Team (Annex E) has primary responsibility for this program. Units in the United States and territories must establish contacts with their local Public Health agency and civilian Emergency Management Coordinator in advance to provide estimates of degree to which local civilian support may be necessary for their beneficiaries. If assets from the National Pharmaceutical Stockpile (NPS) will be necessary to cover AF personnel in the event of a suspected or confirmed bioterrorism attack, units will coordinate request and distribution of these assets through the local public health authority. Information on the NPS is available at **http://www.bt.cdc.gov/Planning/index.asp**. If pharmaceuticals are required, up-channel the request via OPREP PINNACLE to the air staff and National Military Command Center and separately via the cognizant State health authority. Overseas installations report via OPREP PINNACLE. Overseas installations should maintain a full compliment of BW/CW countermeasures for all military in their WRM stocks per AFMAN 23-110 Volume 5, Chapter 15.

A2.2.15. Annex O. Transportation. Address requirements for medical transportation, materiel handling, and personnel support. Primary emphasis on wartime requirements is on movement, marshalling and staging of all medical resources to fulfill mission requirements, sheltering of vehicles (as applicable), and reference to appropriate base support plans. Peacetime considerations are relocation of supplies, equipment, and personnel to the alternate medical facility, as well as patient transport considerations.

A2.2.16. Annex P. Alternate Facility. Outline procedures for rapid transition from the medical facility to an alternate facility. Establish the level of care provided at the alternate facility. This annex must include the following (if another medical facility is planned for use, MOUs/MOAs must support the alternate facility):

A2.2.16.1. Length of time the facility will be used.

A2.2.16.2. Scope of service available at the alternate facility.

A2.2.16.3. A floor plan outlining space allotment for the various patient care activities.

A2.2.16.4. Food service agreements.

A2.2.16.5. Plan for movement of patients, equipment and supplies, including linen.

A2.2.16.6. Reference to local support agreements and implementation policy. Do not include the actual agreements in the MCRP, but indicate their location in the medical facility.

A2.2.16.7. All communication requirements and arrangements to meet requirements.

A2.2.16.8. Hazardous materiel procedures.

A2.2.17. Annex Q. Shelter Operations. According to installation shelter program guidelines, medical units will identify shelters for protecting or housing personnel. (See AFMAN 32-4005, Personnel Protection and Attack Actions.) Outline procedures for movement to the shelter. Indicate the type or extent of medical care that will be available in the shelter. Planning is based on the types of disasters most likely to occur in the particular area. Keep the formal shelter plan in the MCC and in the designated shelter. Delineate which activities are applicable to peacetime or wartime, only.

A2.2.18. Annex R. NDMS Peacetime Operations. MTFs designated as NDMS FCCs prepare this annex. The MCRP can reference separately developed NDMS operations or patient reception plans that describe NDMS operations and are used instead of this annex. MTFs not designated as FCCs can use this annex to describe potential involvement with NDMS operations, if applicable.

A2.2.19. Annex S. Deployment. Describe the unit's plan for mobilizing forces and force reception. Refer to Annex A and G for additional deployment processing guidance.

A2.2.20. Annex T. Disaster Response and Recovery. Use this annex to describe response and recovery procedures for "worst case" scenarios, such as a catastrophic natural disaster directly affecting your installation and facility. Address scenarios in which a disaster renders the base and medical facility partially or totally inoperable. Work with base CE Readiness Flight staff in developing this annex. Discuss protective measures (personnel and resources), phases of response, and recovery procedures. Include comprehensive procedures for evacuation or dispersion of patients, medical personnel, and resources. Recovery procedures should address at least the following:

A2.2.20.1. Reconstitution plans for medical personnel and medical resources.

A2.2.20.2. Re-establishing a medical capability.

A2.2.20.3. Establishing an insect and rodent control capability.

A2.2.20.4. Health care for active duty and non-active duty beneficiaries.

A2.2.21. Annex U. Blood Program. Describe procedures, personnel requirements, and facilities necessary to provide blood and blood derivatives for casualty treatment, if applicable. Planning should be consistent with AFI 44-105, Air Force Blood Program, and address situations that require activation of the blood program. Specify provisions for activating the blood donor center, blood transshipment center, or other assigned blood program missions to include procedures for operation and resupply. Indicate agreements with local agencies for obtaining necessary supplies.

A2.2.22. Annex V. Aeromedical Evacuation. Use this annex to describe the AE interface with base response activities, as applicable.

A2.2.23. Annex W. TRICARE. Use this annex to address the role of TRICARE during peacetime and wartime contingency operations.

A2.2.24. Annex X. Facility Expansion. Include facility expansion procedures (if applicable) to include manpower and staffing requirements and utilization. The Chief Nurse will be responsible for the development of this annex.

A2.2.24.1. Appendix 1. Describe facility expansion procedures and floor plan, as applicable.

A2.2.25. **Attachment 1**. Distribution. See paragraph **3.3.1.**

Attachment 3

MEDICAL UNIT READINESS TRAINING (MURT) MATRIX

Table A3.1. MURT Training Requirements.

(1)	Training Requirement	(2)	Frequency	(3) Duration (Hrs)	Reference	Definition	Remarks
CORE REQUIREMENTS (16 hours)							
D	USAF Medical Service Mission/ Doctrine Briefing	C	Initial/As directed by MAJCOM	1	DoDI 1322.24, AFI 41-106	Includes AEF CONOPS (to include cycle information) and AEF medical support (EMEDS), Health Service Support in support of MOOTW/ SOF/Contingency Operations, AFMS Wartime Doctrine. Homeland Defense/WMD awareness. Echelons/stages of care and joint interoperability also included.	
D	Wound Care and Casualty Management (Formerly Wound Mgt)/SABC	C	Every other AEF training cycle	4	AFI 41-106, AFI 36-2238	The clinical aspects of medical management of casualties and disease non-battle injuries. Training includes, at a minimum, gunshot, vascular injuries, burn, neurological, orthopedic, maxillofacial, hypo/ hyper thermal stress and injuries, hypovolemic shock, eye injuries, and use of blood products, as these injuries relate to the full spectrum of contingency operations. Basic principles of triage will also be included.	Clinical AFSC are listed in **Attachment 8** and all AFSCs not listed require SABC. NREMT satisfies the SABC requirement. Technical training students receive SABC in conjunction with 3-level AFSC awarding courses.
D	Combat Stress Control	C	Every AEF training cycle	0.5	DoDD 6490.5	Familiarization with BICEPS principles of CSC management, as well as leadership, communication with troops, unit morale and cohesion and individual psychosocial stressors, before, during and after deployment. The amount, content, and type of training will be appropriate to the rank and responsibility of the Service member.	
D	Medical Effects of NBC Warfare	C	Every other AEF training cycle	2	AFI 10-2501, AFI 41-106	Medical effects of nuclear, biological and chemical warfare, and the medical management of these casualties. Satellite broadcasts of chem, bio and radiation courses will fill this requirement.	Required for all personnel with a clinical AFSC listed in **Attachment 8**.
D	Geneva Convention/ Law of Armed Conflict	C	Annual	1	AFPD 51-4, AFI 41-106, AFI 51-401	Those elements as prescribed by AF/JAG. Requirement mandated by JAG for all personnel.	

(1)	Training Requirement	(2)	Frequency	(3) Duration (Hrs)	Reference	Definition	Remarks
D	Unit Mission Brief	C	Upon unit assignment and every other AEF training cycle	0.5	DoDI 1322.24, AFI 41-106	Detailed explanation of the unit's role during mobilization in support of War winning, Humanitarian, and Disaster Response operations. At a minimum, CONOPS, deployment sequence, and medical unit commander's intent must be included.	
D/F	Casualty Movement	C	Every other AEF training cycle	1	AFI 41-106	Basic principles triage should be reviewed. Techniques and procedures used to move casualties from one point to another. Should include basic litter carries, casualty loading, and casualty evacuation as appropriate to unit mission. A review of the movement of casualties through the echelons of care will also be included.	
D/O	AFSC-specific Readiness Skills Verification Program (RSVP) (Formerly Warskill Competencies)	C	As specified within RSVP	AFSC-specific	AFI 41-106	IAW AFI 41-106.	Credit may be given for civilian experience. Best Practice suggests this be accomplished during AT (AFSC tng), i.e., Top Star, Med Star, AECOT, tng at MTF, Indian reservation.
D	MCRP/EMP Training	C	Annual	Team specific	AFI 41-106	Requirements determined by MCRP/EMP annexes and Base Support Plans (i.e., driven by local requirements). See **Attachment 2** for MCRP annexes.	Not applicable to RC and AE
DEPLOYMENT REQUIREMENTS (6.5 hours)							
O	Combat Arms Training	D	Biennial for AC and Triennial for ARC	4	AFI 36-2226, AFI 41-106, AFPD 16-8	For qualifications, frequency of training, and numbers required by UTC, this element is prescribed IAW AFIs.	Dual qualification for enlisted couriers and aircrew

(1)	Training Requirement	(2)	Frequency	(3) Duration (Hrs)	Reference	Definition	Remarks
O	NBCC Defense (Formerly CBWDT Refresher)	D	Not to exceed (NTE) 15 months	4	AFI 10-2501, AFI 41-106, AFMAN 10-100	Instruction in the proper wear and use of the ground crew ensemble and mask during the various MOPP conditions. Includes understanding of alarms signals and use of personal chemical detection kits.	Initial within 60 days for military/emergency essential civilians "subject to deploy" or "identified to deploy" to a NBCC medium or high threat area. Coordination with local CEX/DP necessary. See reference CE AFIs for additional guidance.
O	NBCC Defense Task Qualification Training (TQT) (Formerly GROUND TQT) **(4)**	**D**	Not to exceed (NTE) 15 months	Determined locally, 2	AFI 10-2501, AFI 41-106	Minimum tasks to be performed will be identified by the SG Consultants/Career Field Managers in the RSVP/ CFETP. Topics may include loading and unloading casualties, litter carries, operating communication equipment, performing SABC, accomplishing reports, unexploded ordinance (UXO) procedures, and auto injector use.	May be accomplished concurrently with NBCC defense training. Includes donning and doffing.
O	UTC Training	D	Every AEF training cycle	Based on equipment availability	AFI 41-106	Training will include discussion of UTC CONOPS and AS review; hands-on experience with equipment is required for those units co-located with equipment sets. (See para **5.9.1.**) Discussion on interoperability with other UTCs included. Applies to in-place wartime missions.	All FFCC* UTCs must attend initial formal training course as part of UTC training and will be SORTS reportable.
D	Deployment Process	D	Every AEF training cycle	1	AFI 10-403	Review of mobility folders, covering wills, Power Of Attorney, immunizations, personal mobility bag requirements, processing line expectations, and other wing unique requirements. Deployment exercise requirements are IAW AFI 10-403.	Each UTC or mobility position is required to process annually. May count deployment processing.
O	Explosive Ordnance Reconnaissance (EOR)	D	Initial and refresher as determined by MAJCOM	Determined locally, 0.5	AFI 10-2501, AFI 10-403, AFMAN 10-100	Instruction should include basic recognition of standard EOR, and the proper documentation and reporting of EOR.	Suggested to be performed in conjunction with NBCC defense training.
FIELD REQUIREMENTS(5) (5.5 hours)							
F	Shelter Assembly	F	Every AEF training cycle	1	DoDI 1322.24, AFI 41-106	Safe, ergonomic approach to shelter assembly training will be consistent with those shelters appropriate to that unit's mission.	

(1)	Training Requirement	(2)	Frequency	(3) Duration (Hrs)	Reference	Definition	Remarks
F	Field Sanitation and Hygiene	F	Every AEF training cycle	1	DODI 1322.24, AFI 10-219v5, AFI 41-106, AFH 10-222v4	Personal hygiene, food and water handling, waste disposal (human and medical), and other medical responsibilities to educating force. Field sanitation and hygiene is an integral process of disease prevention.	
D	Disease Prevention	F	Every AEF training cycle	0.5	DoDI 6490.3, DoDI 1322.24, AFI 41-106	Operational measures and identification on: countering endemic disease, prevention of non-battle injuries, mental health, countering disease vectors (field/urban) environments, countering health threats in the environment, and force health surveillance.	Should be taught in conjunction with Field Sanitation and Hygiene.
D	Threat and Future Battlefield Environment	F	Every AEF training cycle	0.5	DoDI 1322.24, AFI 41-106	Overview of foreign and domestic sources of imminent danger to US Forces stationed CONUS and OCONUS. Discussion of future battlefield settings where new weaponry may be used effecting the nature of injuries (i.e., laser weapons, particle beams, bio-terrorism, WMD, etc.). Future impact of Force Health Protection measures (developing vaccines, use of PIC Cards). Use most current intelligence production information available to meet the mission intelligence needs.	
D	Depleted Uranium (DU)	F	Initial	0.5	AFI 41-106, AFMAN 32-4005	Training should concentrate on diagnosis and treatment of casualties wounded or contaminated by DU munitions.	Applies to all physicians, nurses, nurse practitioners, dentists, physician assistants, medical technicians, and aeromedical technicians assigned to UTCs
F	Low-Light & Black-Out Operations (Formerly Night Ops)	F	Every other AEF training cycle	2	AFI 41-106	Conduct medical operations during non-daylight hours. Casualty reception and treatment at night primary focus. Include effects of individual night vision blindness.	
JUST-IN-TIME (2 hours)							

(1)	Training Requirement	(2)	Frequency	(3) Duration (Hrs)	Reference	Definition	Remarks
D	Command, Control, Communications, Intelligence, Surveillance, and Reconnaissance (C3ISR) (Formerly C4I)	J	Initial & JIT	0.5	DoDI 1322.24, AFI 41-106	Those activities that use information and business management systems to facilitate day-to-day operations in support of operational missions. This includes the use of radio communications, IM/IT (Information Management/Information Technology), TMIP (Theater Medical Information Program) and other technology insertions (GEMS).	
D	Site Selection	J	JIT	0.5	DoDI 1322.24, AFI 41-106	Guidance to evaluate a bed down site for deployed forces, emphasis is on site topography, vegetation, water sources, vector breeding sites, climate, evacuation routes, field sanitation requirements, and facility location.	
D	Medical Intelligence	J	JIT	0.5	AFI 41-106	Brief the medical threats/countermeasures at deployed locations to include endemic diseases, environmental hazards, hazardous insects, plants and animals, food and water precautions, field sanitation and hygiene considerations and WMD countermeasures.	
D	Interactions with Civilian and Federal Agencies (include NGO – Non-Government Organizations)	J	JIT	0.5	AFI 36-2250, AFI 41-106	Coordination between civilian support agencies such as hospitals, contracting, logistic supply lines, Red Cross, FEMA, and other disaster relief agencies.	Only applicable for units who have agreements with civilian/ NGO organizations
OTHER							
Medical Management of Biological Warfare Casualties						**Initial Only for Clinicians/Providers (see definition of Provider)**	

(1) Primary method of instruction: D = Didactic Element, F = Field Element, O = Other Exercise Element

(2) Content category: C = Core Requirement (applies to all AFMS personnel), D = Deployment Requirements (applies to all deployable personnel), F = Field Training (applies to those assigned to deployable UTCs), J=Just-In-Time based on an actual deployment location)

(3) Duration – Times are in hours and are guidelines for planning purposes not mandated time periods

(4) MAJCOMs should add additional items to meet MAJCOM mission needs

(5) Formal Field Training for ARC units is every four AEF training cycles (For ANG units, training is based on ANG/SG training guidance.)

Attachment 4

MURT EQUIVALENCY MATRIX[1]

Table A4.1. MURT Equivalency Matrix.

	AECOT	JRTC	EMRC/ BEMRT	MRIC	CRTC	EMEDS	C4	JOMMC	CCATT	FN	ConOps	RMRFT	ASTS
CORE REQUIREMENTS													
USAF Medical Service Mission and Doctrine Briefing/Unit Mission briefing/CONOPS	X	X	X	X	X			X		X		X	X
Wound Care			X	X	X	X	X					X	
Casualty Management	X	X	X	X	X	X	X			X		X	X
Combat Stress Control		X	X	X	X		X					X	
Medical Effects of NBC Warfare			X	X	X	X				X	X	X	X
Geneva Convention/Law of Armed Conflict		X	X	X	X			X		X		X	X
Casualty Movement	X	X	X	X	X	X	X	X	X	X		X	X
AFSC-specific Training (RSVP)						X			X			X	
MCRP Exercise													
DEPLOYMENT REQUIREMENTS													
Combat Arms Program					X								
Explosive Ordinance Reconnaissance (EOR)		X	X	X	X							X	
NBCC Defense[2]			X	X	X		X				X	X	X
NBCC Defense TQT[2]		X	X	X	X							X	
Deployment Process	X	X										X	X
FIELD REQUIREMENTS													
Shelter Assembly	X	X	X	X	X	X	X					X	X

	AECOT	JRTC	EMRC/ BEMRT	MRIC	CRTC	EMEDS	C4	JOMMC	CCATT	FN	ConOps	RMRFT	ASTS
Field Sanitation &Hygiene	X	X	X		X	X				X	X	X	
Threat & Future Battlefield Environment		X	X	X	X	X	X	X			X	X	
UTC Training	X	X				X			X				
Low-Light, & Blackout Ops	X	X	X	X	X	X	X					X	
Disease Prevention		X				X						X	
JUST-IN-TIME													
C3ISR	X	X	X	X	X	X	X	X				X	
Site Selection		X	X		X	X				X	X	X	X
Medical Intelligence	X	X	X	X	X	X		X			X	X	
Interactions with Civilian Activities Including NGOs		X	X		X						X		

Legend:

AECOT (Aeromedical Evacuation Contingency Operations Training), Sheppard AFB, TX

JRTC (Joint Readiness Training Center), Ft Polk, LA

EMRC (Expeditionary Medical Readiness Course), Sheppard AFB, TX

BEMRT (Basic Expeditionary Medical Readiness Training), Brooks AFB, TX

MRIC (Medical Readiness Indoctrination Course), Maxwell AFB, AL

CRTC (Combat Readiness Training Center), Alpena, MI

C4 (Combat Casualty Care Course), Camp Bullis, TX

JOMMC (Joint Operations Medical Managers Course, formerly known as C4A), Ft Sam-Houston, TX

CCATT (Critical Care Air Transport Team Course), Brooks AFB, TX

FN (Flight Nurse Course), Brooks AFB, TX

ConOps (Contingency Public Health Operations Course), Brooks AFB, TX

RMRFT (Reserve Medical Readiness Field Training), Sheppard AFB, TX

ASTS (Aeromedical Staging Squadron Course), Sheppard AFB, TX

NOTES:

1. The blocks marked with an X indicate the requirements that are considered accomplished after successful completion of the entire course indicated.
2. NBC Defense and TQT refresher is provided as initial training.

Attachment 5

MINIMUM WEAPONS REQUIREMENTS FOR DEPLOYING AFMF UTCS

Table A5.1. Minimum Weapons Requirements for Deploying AFMS UTCs.

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFAAR	2	5	1	3	4
FFAAS	0	1	0	1	1
FFAAT	2	4	1	3	4
FFANC	3	6	2	4	6
FFBAT	1	1	1	1	2
FFBD1	0	12	0	6	6
FFBMM	0	3	0	0	0
FFBTP	1	11	1	7	8
FFBU1	0	6	0	3	3
FFBU2	0	1	0	1	1
FFBU3	1	0	1	0	1
FFC2A	9	20	3	8	11
FFCCE	2	1	3	0	3
FFCCT	2	1	3	0	3
FFCCU	6	8	0	0	0
FFCCV	13	13			
FFDAB	1	2	1	2	3
FFDAD	1	3	1	3	4
FFEB1	70	151	32	68	100
FFEB2	17	2	8	1	9
FFEC1	84	203	35	85	120
FFEC2	47	96	21	40	61
FFEC3	23	62	11	31	42
FFEC4	27	65	12	32	44
FFEC5	38	83	18	41	59
FFEND	1	1	0	0	0
FFENT	1	1	0	0	0
FFEP1	2	1	2	1	3
FFEP2	3	2	3	2	5
FFEP3	7	20	4	10	14

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFEP4	11	14	6	7	13
FFEP5	3	2	0	0	0
FFEP6	1	4	0	0	0
FFEPT	27	40	9	13	22
FFEST	13	9	5	3	8
FFEW1	7	18	3	6	9
FFEW2	7	13	3	5	8
FFEWT	14	31	5	11	16
FFEYE	1	1	0	0	0
FFF0C	2	4	1	2	3
FFGK1	18	12	5	10	15
FFGK2	13	16	8	11	19
FFGK3	14	30	10	20	30
FFGK4	5	24	3	15	18
FFGK5	13	36	9	24	33
FFGK6	7	4	4	3	7
FFGK7	7	4	4	3	7
FFGK8	2	2	4	4	4
FFGK9	5	14	2	7	9
FFGKE	67	147	34	74	108
FFGKF	32	98	15	45	60
FFGKH	30	43	15	25	40
FFGKL	4	20	2	10	12
FFGKM	6	13	3	6	9
FFGKN*	0	2	0	2	2
FFGKR	1	3	0	0	0
FFGKT	3	0	0	0	0
FFGKU	4	2	4	2	6
FFGKV	2	1	2	1	3
FFGL1	1	5	1	5	6
FFGL2	2	0	2	0	2
FFGL3	1	1	2	0	2
FFGL4	0	4	0	4	4

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFGLB	0	19	0	19	19
FFGLE	1	12	1	12	13
FFGRL*	3	1	3	1	4
FFGYM	4	2	2	1	3
FFGYN	2	3	2	2	2
FFHA1	5	2	4	2	6
FFHA2	8	7	4	4	8
FFHA4	1	2	0	1	1
FFHA5	2	0	1	0	0
FFLAB**	10	29	16	23	39
FFLBD	6	21	2	5	7
FFLCA	22	64	5	15	20
FFLEA	41	139	11	34	45
FFLG1	0	3	0	0	0
FFLGC	1	8	0	0	0
FFLGD	0	6	0	0	0
FFMAX	1	1	0	0	0
FFMFS	5	0	5	0	5
FFNEU	1	1	0	0	0
FFPDD	1	1	0	0	0
FFPED	10	9	0	0	0
FFPER	1	1	0	0	0
FFPME	1	9	1	4	5
FFPPT	1	1	0	1	1
FFPRM	10	12	10	11	22
FFQAC	4	4	0	0	0
FFQAD	3	5	0	0	0
FFQAE	1	6	0	0	0
FFQB9	10	15	25	0	25
FFQBB	0	2	0	2	2
FFQC1	2	0	0	0	0
FFQC3	4	1	4	1	5
FFQC4	2	1	3	0	3

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFQCE	20	30	50	0	50
FFQCK	2	3	5	0	5
FFQCQ	40	60	100	0	100
FFQCT	0	5	0	5	5
FFQCU	8	11	8	11	19
FFQCV	3	3	0	6	6
FFQCX	2	3	2	3	5
FFQCY	8	24	8	24	32
FFQDA	2	3	5	0	5
FFQDB	10	15	25	0	25
FFQDC	40	60	100	0	100
FFQDD	20	30	50	0	50
FFQEJ	0	1	0	1	1
FFQEK	1	2	3	2	3
FFQP1	0	2	0	0	0
FFQP2	0	3	0	0	0
FFQPA	0	1	0	1	1
FFRA1	2	5	7	0	7
FFRA2	6	14	20	0	20
FFRA3	2	8	10	0	10
FFRAD	1	2	0	1	1
FFSYS	1	6	0	2	2
FFTEL	1	2	1	1	2

NOTES:

1. Weapons training will be in accordance with established guidance contained in AFPD 16-8, *Arming of Aircrew, Mobility, and Overseas Personnel*, AFI 31-207, *Arming and Use of Force by Air Force Personnel*, AFI 36-2226, *Combat Arms Program*, this instruction, and other applicable directives.
2. There must be a minimum of one qualified individual for each weapon required. The ammunition authorized for each weapon is based on the personnel-arming requirement. For medical personnel specified here, munitions authorizations for internal security, protection, and personal defense are found in AFCAT 21-209, *Ground Munitions*. AFCAT 21-209 also serves as the source for MURT ground munitions authorizations.

3. Handguns will be available for use by designated weapons couriers for each parent UTC with a weapons requirement. These handguns are reflected in the totals above.
4. Procure handguns (9mm) for officers and rifles (M-16) for enlisted personnel, unless otherwise indicated.

   4.1. * The IDMT (4N0X1) assigned to FFGRL/FFGKN, and deploying or supporting a TDY requirement as the single medical authority supporting deployed/other TDY personnel is authorized either M9, M-16 or both as the situation dictates.

   4.2. ** For the UTC, FFLAB, an additional six M-9's are required to support the six enlisted personnel dual tasked for ground and aircrew responsibilities.

5. With limited exceptions, the ratio of handguns to rifles reflects the UTC officer to enlisted manpower ratio.
6. Bases assigned fragmented portions of UTCs will ensure their tasked personnel are weapons trained and qualified as required by the UTC. If the arming requirement is 100 percent for that UTC, then all personnel assigned by both the lead unit and any fragged portions will be weapon qualified. If the arming requirement is less than 100 percent, then the applicable percentage of personnel assigned will be qualified, as required by the UTC. The lead unit for identified taskings will ensure personnel in fragged UTCs supporting them have weapons available to support identified requirements. ***EXAMPLE***: If the UTC requires 50 percent of total personnel be weapons qualified, then both the lead unit and any bases assigned a portion of that UTC will ensure that 50 percent of the total number of their personnel assigned to the UTC will be weapon qualified. Both the lead unit and any fragged units will ensure the applicable training requirement is met.
7. CONUS units with generation missions/UTC taskings are exempt from weapons requirements.
8. Medical units on the Korean Peninsula will use the following guidance for determining weapons requirements:

   8.1. Weapons are required for at least 50% of medical authorizations. Personnel assigned to UTCs should be given priority and comply with weapons' training requirements. The MDG Commander will determine additional weapons' requirements above 50% of authorizations.

9. Annually, pilot units are responsible for determining and recommending weapons requirements for each assigned UTC to the MAJCOM MEFPAK responsible for managing the UTC.

Attachment 6

SAMPLE FIELD TRAINING SCHEDULE FOR MEDICAL UNITS

Table A6.1. Sample Field Training Schedule.

STARTEX **DAY ONE**		
TIME	**A-SHIFT**	**B-SHIFT**
0530-0630	Deployment Processing	Deployment Processing
0630-0730	USAF Medical Service Mission/Doctrine Briefing	USAF Medical Service Mission/Doctrine Briefing
0730-0800	Site Selection	Site Selection
0800-0900	Transportation to MURT Field Site	Transportation to MURT Field Site
0900-1230	Field Gear Issue/Camp Set-Up	Field Gear Issue/Camp Set-Up
1230-1330	Lunch	Casualty Movement
1330-1430	Field Sanitation and Hygiene	Lunch
1430-1530	Casualty Movement	Field Sanitation and Hygiene
1530-1600	C3ISR	Interaction with NGO
1600-1700	Dinner	Dinner
1700-1730	Interaction with NGO	C3ISR
1730-2130	Wound Care & Casualty Management	Wound Care & Casualty Management
2130-2330	Low Light/Blackout Operations	Low Light/Blackout Operations
2330-0600	Off-duty	Off-duty
DAY TWO		
0600-0700	Breakfast	Breakfast
0700-0800	Medical Effects of NBC	Geneva Convention, and LOAC
0800-0900	Medical Effects of NBC	Shelter Assembly
0900-0930	Combat Stress Control	Disease Prevention
0930-1030	Shelter Assembly	Medical Effects of NBC
1030-1130	Geneva Convention, and LOAC	Medical Effects of NBC
1130-1230	Lunch	Lunch
1230-1300	Disease Prevention	Threat and Future Battlefield
1300-1330	Threat and Future Battlefield	Combat Stress Control
1330-1600	Mass Casualty Exercise	Mass Casualty Exercise
1600-1630	Exercise Debrief	Exercise Debrief
1630-1800	Site Tear-Down/Equipment Turn-In	Site Tear-Down/Equipment Turn-In
1800-1830	Return to Home Base	Return to Home Base
ENDEX		

Attachment 7

SUMMARY OF READINESS EXERCISES

Table A7.1. Summary of Readiness Exercises.

EXERCISE REQUIREMENT	FREQUENCY	AUDIENCE	REFERENCE	REMARKS
Mass Casualty	Annually	Scenario dependent	AFI 41-106, (AFI 10-2501	All medical personnel
Assemblage Set Up, Inventory, and Exercise	Every AEF training cycle for set-up/ inventory, and every other cycle for exercise	All personnel assigned to UTC with access to WRM equipment	DoDI 1322.24, AFI 41-106	Train to extent possible for equipment/ assemblage proficiency
Alternate Medical Treatment Facility	Every other AEF training cycle	Scenario dependent	AFI 41-106	Not applicable to ARC
Field Exercise/ Training	Every other AEF training cycle	Deployable personnel and as defined by MAJCOM/SG	DoDI 1322.24, AFI 41-106	ANG field exercises will be conducted on an every fourth cycle basis. AFRC field exercise will be conducted on an every other cycle.
Pre-Positioned WRM	As directed by MAJCOM	Applicable WRM assemblage	AFI 41-106	Consists of PMI and inventory reports. Not applicable to ANG.
NDMS	Annually	Scenario dependent	AFI 41-106	Exercise involvement driven by Federal Coordinating Centers
(The following exercises are driven by guidance external to this instruction.)				
Major Accidents - Munitions - Nuclear weapons - Off-base response - Air Show response - HAZMAT Team	Annually for each category applicable for medical unit	Scenario dependent	AFI 10-2501, FSTR Plan 10-2	For ARC Units: IAW Base/Wing exercise schedule and Commander's discretion.

EXERCISE REQUIREMENT	FREQUENCY	AUDIENCE	REFERENCE	REMARKS
Terrorist Use of WMD - Chemical, radiological, nuclear, or high-yield explosive incident - Biological attack incident	Biannually for each category	Scenario dependant	AFI 10-2501	Execute cross-functionally according to the local WMD threat: incorporate all local response elements. Alternate annually between the two categories of Terrorist Use of WMD exercises.
Enemy Attack	- Not to exceed 15 months for installations in a chem/bio LTA - Not to exceed 7.5 months for installations in a chem/bio MTA - Quarterly for installations in a chem/bio HTA	Scenario dependent	AFI 10-2501	Not applicable for ARC, but should be included in mass casualty exercises on a regular basis
Natural Disaster Response	Annually	Scenario dependent	AFI 10-229, AFI 10-2501	Natural disaster response typical to unit area. Not applicable for ARC, but should be included in mass casualty exercises on a regular basis.
Mobilization Exercise	Annually	All assigned to deployment status and deployment teams	AFI 10-402, AFI 10-403, AFPAM 10-219V1, AFPAM 10-417, AFH 10-416	Exercise entire range of deployment responsibilities
Recall	IAW Base/Wing exercise schedule and commander discretion	Scenario dependent	AFI 10-403	Evaluate capability to implement unit or UTC recall plan

Attachment 7 (PACAF)

Table A7.1. (PACAF) Summary of Readiness Exercises.

EXERCISE REQUIREMENT	FREQUENCY	AUDIENCE	REFERENCE	REMARKS
Pre-positioned WRM	Two CP-EMEDS+ 25 per year, on a 3 year cycle	Pre-Positioned WRM assets in Korea	AFI 41-106 PACAFSUP 1	See (ADD) **5.9.2.2. (Added)**
Pre-positioned ASF/MASFs	Once every 3 years	ASF/MASFs pre-positioned at PACAF bases	AFI 41-106 PACAFSUP 1	See (ADD) **5.9.2.3. (Added)**
Air Transportable Clinics	IAW **Attachment 7**	Squadron Medical Elements (SME) assigned to flying squadrons	AFI 41-106	See (ADD) **5.9.2.1. (Added)**

Attachment 8

CLINICAL AFSC LISTING

Table A8.1. Listing of Clinical AFSCs.

AFSC	CORPS	DESCRIPTION
42B3	BSC	Physical Therapist
42E3	BSC	Optometrist
42F3	BSC	Podiatrist
42G3	BSC	Physician Assistant
42G3A	BSC	Physician Assistant, Ortho
42G3B	BSC	Physician Assistant, ENT
42G3C	BSC	Physician Assistant, Gen Surgery
42G3D	BSC	Physician Assistant, Perfusionist
42G3E	BSC	Physician Assistant, Emergency Room
42G3F	BSC	Physician Assistant, Oncology
42T3	BSC	Occupational Therapist
43B3A	BSC	Chiropractor
43Y3A	BSC	Health Physicist Med
44A3	MC	Chief Hospital/Clinic Services
44B3	MC	Preventive Medicine Specialist
44D3	MC	Pathologist
44D3A	MC	Pathologist, Hematology
44D3B	MC	Pathologist, Cytology
44D3C	MC	Pathologist, GYN
44D3D	MC	Pathologist, Forensic
44D3E	MC	Pathologist, Neuropathology
44E3	MC	Emergency Services Physician
44E3A	MC	Emergency Services Phys, Emergency Specialist
44F3	MC	Family Physician
44G3	MC	General Practice Physician
44H3	MC	Nuclear Medicine
44K3	MC	Pediatrician
44K3A	MC	Pediatrician, Adolescent
44K3B	MC	Pediatrician, Cardiology
44K3C	MC	Pediatrician, Developmental Ped
44K3D	MC	Pediatrician, Endocrinologist

AFSC	CORPS	DESCRIPTION
44K3E	MC	Pediatrician, Neonatologist
44K3F	MC	Pediatrician, Gastroenterologist
44K3G	MC	Pediatrician, Hematologist
44K3H	MC	Pediatrician, Neurologist
44K3J	MC	Pediatrician, Pulmonologist
44K3K	MC	Pediatrician, Infectious Disease
44K3L	MC	Pediatrician, Medical Genetics
44K3M	MC	Pediatrician, Nephrologist
44M3	MC	Internist
44M3A	MC	Internist, Oncologist
44M3B	MC	Internist, Cardiologist
44M3C	MC	Internist, Endocrinologist
44M3D	MC	Internist, Gastroenterologist
44M3E	MC	Internist, Hematologist
44M3F	MC	Internist, Rheumatologist
44M3G	MC	Internist, Pulmonary Diseases
44M3H	MC	Internist, Infectious Diseases
44M3J	MC	Internist, Nephrologist
44N3	MC	Neurologist
44P3	MC	Psychiatrist
44P3A	MC	Psychiatrist, Child Psych
44R3	MC	Diagnostic Radiology
44R3A	MC	Diagnostic Radiology, Neuroradiology
44R3B	MC	Diagnostic Radiology, Special Procedures
44S3	MC	Dermatologist
44S3A	MC	Dermatologist, Derm Surgery
44S3B	MC	Dermatologist, Derm Pathology
44T3	MC	Radiotherapist
44U3	MC	Occupational Medicine Specialist
44Y3	MC	Critical Care Medicine
44Y3A	MC	Critical Care Medicine, Pediatrics
44Z3	MC	Allergist
45A3	MC	Anesthesiology
45B3	MC	Orthopedic Surgeon
45B3A	MC	Orthopedic, Hand

AFSC	CORPS	DESCRIPTION
45B3B	MC	Orthopedic, Pediatrics
45B3C	MC	Orthopedic, Biomechanical
45B3D	MC	Orthopedic, Sports Medicine
45B3E	MC	Orthopedic, Spine Surgery
45B3F	MC	Orthopedic, Oncology
45B3G	MC	Orthopedic, Replace Arthroplasty
45E3	MC	Ophthalmologist
45E3A	MC	Ophthalmologist, Oculoplastics
45E3B	MC	Ophthalmologist, Cornea/External Disease
45E3C	MC	Ophthalmologist, Glaucoma
45E3D	MC	Ophthalmologist, Neuro-Ophthalmologist
45E3E	MC	Ophthalmologist, Pathology
45E3F	MC	Ophthalmologist, Strabismus/Ped
45E3G	MC	Ophthalmologist, Vitreous/Retina
45G3	MC	OB/GYN
45G3A	MC	OB/GYN, Endocrinologist
45G3B	MC	OB/GYN, Oncology
45G3C	MC	OB/GYN, Pathology
45G3D	MC	OB/GYN, Maternal-Fetal Medicine
45N3	MC	ENT
45P3	MC	Physical Medicine Physician
45S3	MC	Surgeon
45S3A	MC	Surgeon, Thoracic
45S3B	MC	Surgeon, Colon/Rectal
45S3C	MC	Surgeon, Cardiac
45S3D	MC	Surgeon, Pediatric
45S3E	MC	Surgeon, Peripheral Vascular
45S3F	MC	Surgeon, Neurological
45S3G	MC	Surgeon, Plastic
45S3H	MC	Surgeon, Oncologist
45S3J	MC	Surgeon, Multi-Organ Transplant
45U3	MC	Urologist
45U3A	MC	Urologist, Pediatrics
45U3B	MC	Urologist, Oncology
45U3C	MC	Urologist, Kidney or Pancreas Transplant

AFSC	CORPS	DESCRIPTION
46A3	NC	Nursing Administrator
46P3	NC	Mental Health Nurse
46P3A	NC	Mental Health Nurse Specialist
46S3	NC	Operating Room Nurse
46M3	NC	Nurse Anesthesia
46N3	NC	Clinical Nurse
46N3A	NC	Clinical Nurse, OB/GYN Nurse Practitioner
46N3B	NC	Clinical Nurse, Pediatric Nurse Practitioner
46N3C	NC	Clinical Nurse, Primary Care Nurse Practitioner
46N3D	NC	Clinical Nurse, Staff Development
46N3E	NC	Clinical Nurse, Critical Care
46N3F	NC	Clinical Nurse, Neonatal ICU
46N3G	NC	Clinical Nurse, Obstetrics
46N3H	NC	Clinical Nurse, Family Nurse Practitioner
46F3	NC	Flight Nurse
46G3	NC	Nurse Midwife
47G4	DC	Dental Staff Officer
47G3	DC	Dental Officer
47G3A	DC	Dental Officer, Comprehensive Dentist
47G3B	DC	Dental Officer, Advance Clinical Dentist
47G3C	DC	Dental Officer, General Clinical Dentist
47S3	DC	Oral Maxilofacial Surgeon
47H3	DC	Periodontist
47P3	DC	Prosthodontist
47B3	DC	Orthodontist
47D3	DC	Oral Pathologist
47E3	DC	Endodontist
47K3	DC	Pediatric Dentist
48A3	MC	Aerospace Medicine Physician, Spec
48G3	MC	Aerospace Medicine Physician (non-residency trained)
48R3	MC	Residency Trained Aerospace Medicine (RAM) Physician

AFSC	CORPS	DESCRIPTION
4H0X1	Enlisted	Cardiopulmonary Lab Technician
4J0X2	Enlisted	Physical Therapy Technician
4N0X1	Enlisted	Medical Service Technician
4N090	Enlisted	Medical Service Superintendent
4N0X1A	Enlisted	Allergy/Immunology Technician
4N0X1B	Enlisted	Neurology. Technician
4N1X1	Enlisted	OR, Technician
4N1X1B	Enlisted	OR, Technician, Urology
4N1X1C	Enlisted	OR, Technician, Ortho
4N1X1D	Enlisted	OR, Technician, ENT
4R0XI	Enlisted	Radiology Technician
4R0X2	Enlisted	Nuclear Medicine Technician
4P0X1	Enlisted	Pharmacy Technician
4V0X1A	Enlisted	Ophthalmology Technician
4Y0X1	Enlisted	Dental Technician

Attachment 9 (Added-PACAF)

USE OF WAR RESERVE MATERIEL (WRM)

A9.1. (PACAF) There are three distinct types of WRM in PACAF; prepositioned, deployable and in-place.

A9.1.1. (PACAF) Prepositioned WRM is defined as WRM managed by the host medical logistics account. Specific to this type of WRM, the host medical unit does NOT have the associated personnel UTCs assigned to set up and operate the asset. Prepositioned WRM is associated with caretaker/ inventory and management duties outlined in the mission narrative on the unit's DOC statement.

A9.1.2. (PACAF) Deployable WRM is defined as WRM for which a unit has both equipment and associated personnel UTC assigned. Deployable UTCs that must be exercised IAW this instruction are listed in Section IIC of the unit's DOC statement.

Examples of deployable WRM are as follows:

937B is allowance standard for UTC FFEE2, EMEDS +10 package.

940A is allowance standard for UTC FFEE4, EMEDS Resupply package.

902A is allowance standard for UTC FFGLA, Patient Decon Package.

903I is allowance standard for UTC FFQL1, Mobile Aeromedical Staging Facility, 10-bed.

A9.1.3. (PACAF) In-place WRM is defined as WRM (1) without an associated UTC, (2) identifiable only by an Allowance Standard, and (3) can not deploy because there is no LOGFOR detail. Examples include: Blood Transshipment Center, Frozen Blood Lab, Blood Donor Center, hospital expansion mission, etc.

A9.2. (PACAF) Medical and Aeromedical Units with deployable War Reserve Materiel (WRM) must request the use of these assets from PACAF/SGX NLT 60 days prior to the event. PACAF/SG is the approval authority to take WRM "off-line" for an exercise, inspection, etc. The template below in **Figure A9.1.** will be used to request the use of WRM.

A9.3. (PACAF) Requests/prior approval is not required for in-place WRM, but notification is required. These WRM packages are not deployable, but rather designed to operate in place. It is expected that if WRM is set up and used for a local exercise, blood drive, air show, event, etc., they could still be set up for a contingency or to meet its wartime mission. Units will notify PACAF/SGX when in-place WRM is used, to include how it will be used, what equipment will be used, the dates of the event, and the date it will be fully returned to storage and operational to meet mission requirements. The notification must be sent to PACAF/SGX not later than the first date it will be used. Preferred method of delivery: Electronically via E-mail to **mailto:pacaf/sgx@hickam.af.mil**

Figure A9.1. (PACAF) Request Letter Format For Utilization Of Deployable WRM Assets.

MEMORANDUM FOR HQ PACAF/SGX

FROM: XX MDG/CC
UNIT: XXXXX
APO AP XXXXX-XXXX

SUBJECT: Deployable Medical War Reserve Material (WRM) Request to take Asset off-line

1. Request use of deployable WRM assets to participate in a local Medical/Wing Readiness exercise/ inspection to be conducted on XXXXXX Air Base at XXXXXXX location from XXXXX to XXXXX. 2003. The WRM assemblage(s) requested to be taken off-line is/are listed below:

UTC	ALLOWANCE STANDARD	WRM ASSET
FFXXX	XX	Nomenclature

2. In accordance with AFMAN 23-110, Volume 5, paragraph 15.11.2.5 assets will not be loaned or off-line for over 120 days. Lost, consumed, or damaged assets will be paid for with Operating and Maintenance (O & M) funds from fund cite XXXXXXX.XXXXXXXXXXXXXXXXXXXXXXX. All assets will be inventoried and reconstituted within 30 days of ENDEX.

3. The asset will be inventoried and returned to storage NLT XXXXXX date.

ELECTRONIC E-MAIL SIGNATURE

// Signed //

JOHN W. SMITH, Col, USAF, MSC
Commander, XX Medical Group

Cc:
XX MDG/SGSL
XX MDG/SGPR

Attachment 10 (Added-PACAF)

SORTS CHECKLIST

SORTS CHECKLIST			
		YES	**NO**
1.	Does commander assessed Overall C-levels provide detailed REASN remarks explaining the rationale for why/how they disagree with the SORTS measured area(s)? This includes an up or down assessment by the Commander.		
2.	Are reasons provided for all sub-areas which fall below 1? The reason should include: why – describe the issue; what is being done to correct the problem, to include; for example, how much money was requested, the person contacted at MAJCOM, when person was contacted, and response; when will it be corrected and the rationale – An unacceptable reason is "awaiting funds".		
3.	When the overall C-level is less than C-1, does the REASN remark reflect which specific UTC or capability the unit cannot fully support or undertake, and does it provide a programmed or estimated Get Better/Get Well date?		
4.	If required, has a PRRES remark been submitted to explain why the personnel area is less than P-1?		
5.	Regardless of P-level, has a PERTP remark been submitted identifying personnel shortages based on the UMD?		
6.	If required, has a PRRAT remark been submitted to identify UTC/UMD mismatches?		
7.	Has a CADAT remark been properly formatted and submitted?		
8.	Does the information in the CADAT agree with the "Forecast Date"		
9.	Has a DOCID remark been submitted?		
10.	Is the current DOC statement date reflected in the DOCID remark?		
11.	Have all remarks been updated in the last 30 days?		
12.	Have ESSA remarks been submitted for each category of war reserve material assigned to the unit. For example: Unit is assigned WRM projects that fall under ESSA1, 3, 6, and 9. Remarks for each WRM project within each ESSA will include a % and if less than 90% or critical supply/equipment items, will have a remark summarizing the deficiency, to include dated items, equipment calibration, deployed, etc.		
13.	Have percentages been provided for each project code listed in the ESSA remark?		
14.	Was the lowest WRM % from all ESSAs used as the overall Support Equipment and Supplies %?		
15.	Are ECDs appropriate, attainable and will not be "slipped" the following month? If not, give an ECD farther out to ensure corrective action can be accomplished.		
16.	Remove all ratings listed under "Equipment Condition"		

SORTS CHECKLIST			
		YES	**NO**
17.	Are reasons for deficiencies clear, concise, and detailed enough for the layperson interpreting the SORTS report, e.g. are comments and details written in plain English?		
18.	Has the unit received and verified accuracy of transmitted information via "easy read" or other similar source.		
19.	Is this a change SORTS report? Contact PACAF/SGX BEFORE submitting to discuss the reason for the change to ensure it's warranted/appropriate. Also, contact PACAF/SGX within 24-hours of Command Post inputting data and sending report.		

Attachment 11(Added-PACAF)

C-STARS ATTENDANCE REQUIREMENTS AND AVAILABILITY

Table A11.1. defines the AFSCs and frequency that each MUST attend the C-STARS program. MTF commanders MUST comply with AFI 41-106, paragraph **5.9.4.**, UTC Formal Training.

Table A11.1. (PACAF) C-STARS Atten Criteria.

AFSC	C-STARS Attendance Criteria
45S-3 - Gen Surg	Every two AEF cycles (30 mos) beginning 24 months post residency
44E-3 – Emer Med	Every two AEF cycles (30 mos) beginning 24 months post residency
44Y3 – Critical Care Medicine	Every two AEF cycles (30 mos) beginning 24 months post critical Care fellowship
48A3 – RAM/FS	Upon assignment to a UTC (FFGL2) and as a volunteer to fill training quotas. Then every two AEF cycles when RSVs not met.
45A3 – Anesthesia	Every two AEF cycles (30 mos) beginning 24 Months post residency and/or fellowship
45B3 – Ortho surgeon	Ortho consultant will consider attendance using the following priority: (See Credential Providers Process below) - JSOC assigned - annually - Landstuhl assigned - every two cycles (3 year) - Assigned overseas - other then Landstuhl – every two cycles (3 years) - Assigned to deploying UTCs – if they require trauma refresher - Assigned CONUS - on a volunteer basis
46 M3 – CRNA	Military trained – Every two AEF cycles (30 mos) beginning 24 months post graduation Civilian trained- Every two AEF cycles (30 mos) beginning with consultant's direction (case-by case)
44M3X- Internal Med (includes sub-specs)	Upon assignment to UTC (EP1 and CCE) then every two AEF cycles (30 mos) thereafter
46N3E – Crit Care Nurse	Upon assignment to UTC and every 2 AEF cycles (30 mos) thereafter. Must train to mission capability statement of UTC assigned.
46N3 – Clinical Nurse	Upon assignment to the UTC (FFEP6) and every two AEF cycles (30 mos) thereafter
46S3 – OR Nurse	Upon assignment to UTC and every two AEF cycles (30 mos) thereafter
46F3 – Flight Nurse	As volunteers only when no other 46N3 requires training
4N1XX – OR Tech	Upon assignment to UTC and every two AEF cycles (30 mos) thereafter
4H0XX – CP Tech (includes auth subs)	Upon assignment to UTC and every two AEF cycles (30 mos) thereafter
4N0XX – Med Tech	Upon assignment to UTC and every two AEF cycles (30 mos) thereafter
41A3 - MSC	Do not recommend C-STAR attendance at this time

Allowable UTC substitutions for the AFSCs above are eligible for training (see **Table A11.2.**).

Table A11.2. (PACAF) C-STARS Training Availability by UTC.

C-STARS Training Availability by UTC	
Location	**UTC**
Baltimore	**Primary –** FFEP1, FFMFS, FFEP5, FFEP6, FFCCT, FFGL2 (RAM ONLY) FFGLE, FFQC3, FFQC4 **Alternates** – FFEP3, FFEP4
Cincinnati	FFCCT, FFCCE, FFQC4
St Louis	Any EMEDS UTC (Primary site for ANG personnel)

Attachment 12 (Added-PACAF)

MEDICAL AFTER ACTION REPORT FORMAT

A12.1. (PACAF) Purpose: To provide HQ PACAF/SG and staff with an evaluation, as well as observations and opportunities for improvement to deployment for real-world contingencies, humanitarian operations or exercises. It can and should be used to report on any incident or other significant event relating to Medical Readiness which individual medical group members or large portions of the staff. Categories can be added to the format as appropriate.

The following format is for Medical After Action Report:

MEMORANDUM FOR: (See Distribution List, AFI 41-106, paragraphs **6.9.2.1.** thru **6.9.2.3.** and; HQ PACAF/SGX)

FROM:

SUBJECT: Medical After Action Report

1. Reference: Include those documents having a direct bearing on the activities of the medical mission during the exercise. Also, include documents that may require modification/changes based on the recommendations of this report.

2. Concept. A statement concerning the mission of the medical units involved a general description of the exercise, where and when it was conducted, and any unique operational feature that occurred during the operation/exercise.

3. Significant Activities. Include a resume of significant activities that occurred during planning, preparing, employment, and where applicable, the deployment phase of the operation/exercise.

4. Attainment of Operational/Exercise Objectives. Make a statement about the attainment and scope of medical care at each operating site. Enter the material status of deploying medical unit on arrival at the employment site.

TIME AND DATE:

Deployment

Operationally Ready

Terminated Operations

Completed Repack

Redeployment

Arrival Home Station

5. Manpower. Include an accounting of the medical man-hours used to plan, support, and report on, the operation/exercise.

6. Patient Workload. Include an accounting of patient contacts/procedures. Do not include problems. (May be included as an attachment.)

ARMY AIR FORCE NAVY OTHER TOTAL

Number of Admissions:

Number of Outpatients:

Number of Prescriptions:

Number of x-rays:

Other Pertinent Workload.

7. Professional Information. Include data on climate, weather, environmental factors, topography, etc., that had an affect on medical support or operation procedures. Identify situations of importance, or significant evidence of unusual diseases, etc., experienced during the exercise. Include the primary reasons patients sought medical care, and remark on the significance of environmental conditions.

A. Community environment and sanitation:

(1) Health Services:

(2) Water Supply:

(3) Sewage disposal:

(4) Local restaurants:

(5) Insects and animals affecting health:

(6) Poisonous fish and plants:

(7) Food and dairy products:

(8) Veterinary service impact statement:

(9) Preventive medicine impact statement:

B. Prevalent diseases

C. Preventive medicine measures necessary on and off base.

D. Specific “dos and don’ts,” such as relations with indigenous personnel, traditions, and taboos

E. Medical facilities:

(1) Military medical support available.

(2) Civilian medical support available.

(3) Aeromedical evacuation (military and civilian) need and availability.

(4) Plant physical and design limitations, i.e., ventilation, infection control, x-ray, etc.

F. Current and past industrial activities that may affect health.

G. Environmental threat assessment.

H. Flight Medicine Program. Comments about factors that affected or could have affected aircrew safety or effectiveness.

(1) Flying Safety. Comments on the use and unusual side effects of “Go/No-Go” pills. Indicate numbers of aircrews who used stimulant or sedative drugs. Also, the quantity of drugs issued and consumed, and the quantities recovered.

(2) Personnel and protective equipment used. Problems?

(3) Aircrew combat effectiveness.

(4) Medical training.

(5) Aircrew personnel requirements (including comments regarding aircrew conditioning and transient billets).

(6) Flying activities: Hours flown by flight surgeons. Transient bases visited and evaluated.

9. Observations and Recommendations. Suggest using to record observed discrepancies with recommended corrective actions. Format will comply with Armed Forces Medical Intelligence Agency (AFMIC) and Joint Service reporting requirements. Use one for each observation. Observations and recommendations should be objective and factual with specific definitions or problem areas. Not all findings are of equal importance. List major findings first in the report, and state at what level of command the corrective action should be taken. Corrective action should include directive reference, stock numbers, and cost factors for recommended changes. Commit yourself to a line of action you judge best. All recommendations for modifying assemblages, additions, and deletions must contain a complete item description including cost and quantity. Coordinate this form with medical logistics before submitting.

A. Problem area title.

(1) Observation - Clear, brief statement

(2) Discussion - Facts and criteria

(3) Recommendation - Commit yourself to a line of action you judge best. All recommendations for modifying assemblages, additions, and deletions must contain a complete item description including cost and quantity. Coordinate this report with medical logistics before submitting.

10. Commander Summary. The medical commander must summarize the medical participation in the exercise, including areas where the capabilities of medical care may be enhanced for future exercises, or contingency operations by correcting the deficiencies noted in the above paragraphs. Attention should be given to planning, tactics, and techniques employed during the exercise that could have an effect on worldwide medical missions.

// SIGNED //

Commander or Senior Medical Officer/Technician

TABS:

A - List of Medical Personnel Deployed in Exercise or Operation

B - List of Visitors at Exercise Site

C - Staffing Report

cc to: Deployed Squadron Unit

Cmdr/Wing Cmdr

USAFSAM/PH

AFMIC/CR, Fort Detrick, MD 21710-5004

Attachment 13 (Added-PACAF)

MEDICAL READINESS STAFF FUNCTION COMMITTEE MINUTES TEMPLATE

A13.1. (PACAF) Purpose: To provide the PACAF/SGX, MTF commanders and MRO/MRNCO with a simple but comprehensive method of monitoring, reviewing and tracking the Medical Readiness standard agenda items identified with AFI 41-106, para **2.2.**, Minimum Standard Agenda Items. This template in **Figure A14.1.** can be downloaded from the PACAF/SGX webpage.

Figure A13.1. (PACAF) Medical Readiness Staff Function Committee Minutes Template.

MEDICAL READINESS STAFF FUNCTION (MRSF) Combined Minutes & Agenda Tracker		Date Time
Attendees: 100 % present		
Voting Members Present	**Corps**	**Position**
		Commander, Medical Group (Chairperson)
		Deputy Commander, Medical Group
		Commander, Dental Squadron
		Commander Aerospace Medicine
		Commander, Medical Operations Squadron
		Commander, Medical Support Squadron
		Commander, Medical Surgical Squadron
		Medical Readiness Officer
		OIC Medical Logistics
Non-Voting Members Present		**Position**
		Chief of the Medical Staff
		Chief Nurse
		Superintendent, Medical Group
		Squadron Superintendents
		OIC/NCOIC War Reserve Materiel (as applicable)
		Medical Intelligence Officer (Public Health Flight Commander)
		NBC Medical Defense Officer (Bioenvironmental Engineer Flight Commander)
		EMEDS Commander (as applicable)
		Superintendent/NCOIC, Medical Readiness Flight

		Superintendent/NCOIC, Medical Logistics Flight
		Primary DCG Representative/Health Promotion Flight Commander (representing ASF/CC)
		Exercise and Evaluation Team Chief
		Unit Deployment Manager
		Self-aid Buddy Care Representative
		NCOIC Bioenvironmental Engineering
		Recorder (Secretary)
Voting Members Absent		
Non-Voting Members Absent		

1. Review of Previous Minutes	- Minutes from the (DATE), Medical Readiness Function Meeting (MRSF), were reviewed and approved

2. Standard	**Comments and Actions**	**Date Opened**	**Update /ECD**	**OPR**	**Status**
	Item is open for first time				**Blue**
	Item is open for the second MRSF meeting and on-track for closure action or information only.				**Green**
	Item may be experiencing difficulties meeting Estimated Closure Date (ECD)				**Yellow**
	Item is not meeting closure date or otherwise experiencing problems, which are preventing its resolution, or item is open for more than 3 consecutive MRSF meetings. Potential for mission degradation.				**Red**
A. Staffing					
	Total Personnel **Assigned** **Authorized** **Percent**				

	Critical AFSC				
	Assigned				
	Authorized				
	Percent				
	UTC/AFSC Tasked and Filled				
	Requirements Tasked				
	Requirements Filled				
	Percent				
B. War Reserve Material Status By Allowance Standard					
C. Medical Readiness/Training					
(1) UTC Training (By UTC)					
(2) Deployable UTC Training (IAW AFI 41-106)					
(3) Disaster Team Training (By Team)					
(4) Readiness Skills Verification (RSV) Update					
	Medical Corps RSVP Update				
	Nurse Corps RSVP Update				
	Dental Corps RSVP Update				
	MSC Corps RSVP Update				
	BSC Corps RSV Update				
	Enlisted RSV Training				
D. Force Health Protection Issues					
E. Medical Readiness Plans and Regulations Status and Current Date(s)					
	(1) MCRP				
	(2) Base Support Plan (BSP)				

	(3) Weapons of Mass Destruction (WMD) Installation Actions				
	(4) Installation Deployment Plans (IDP)				
	(5) Other Issues				
G. Medical Intelligence Briefing					
H. WMD/Homeland Defense Program					
(1) Training					
(2) Exercises					
(3) Supply/Equip Status					
(4) Other Issues					
I. EET Chief Report					
	**examples—team composition, EET training, exercise objectives				
J. Post Exercise (Issues, Findings, Deficiencies, Schedules, etc)					
K. Future Exercises and Training Events (90-day Look)					
L. Deployments (Current, Planned, and Post)					
M. Mirror Force					
(1) OSATS					
(2) IMA Issues					
(3) Other Issues					
N. Recalls					

O. Other Readiness Issues					
3. Items Referred to Executive Committee					
	1.				
	2.				
4. MRSF Adjournment Time:					
5. Next Meeting Date and Time:					
6. Recorder Signature		Recorder			
7. Medical Readiness Officer Signature		Medical Readiness Officer			
8. Reviewer Signature		Minutes Reviewer			
9. Approval (MDG/CC)		Commander, Medical Group			

Attachments	
1.	
2.	
3.	
4.	
5.	

Attachment 14 (Added-PACAF)

OVERSEAS ANNUAL TRAINING (OSAT)

A14.1. (PACAF) HQ PACAF/SGX will facilitate OSAT requests for PACAF units in conjunction with AFRC and ANG, PACAF units and PACAF reserve liaisons.

A14.2. (PACAF) The process to request and appropriately match Reserve Command (RC) units for Overseas Annual Tours as follows:

A14.2.1. (PACAF) PACAF/SGX sends out "call" in January for units to provide ability to support OSATs for the following FY summer, i.e. Jan 04 for FY05. The bases will provide:

How many OSATs each unit can support.

Dates each unit can support OSATs.

Minimum and maximum number of people for each OSAT, to include conducting MURT.

Any limiting factors, i.e. lodging, transportation, etc.

Figure A14.1. below will be used for the unit to provide the information.

Figure A14.1. (PACAF) Template for Overseas Annual Training (OSAT).

PACAF UNIT	# of OSATs	DATES	MIN	MAX	UNITS	UTCs	PER		Reserve Unit	UTC	DATE	Remarks
15 MDG, Hickam	2	May-03	10	30	Minnesota ASTS	FFLBD	27					
					Timbuktu ARB	FFDAB	3					
		Jul-03			Tallahassee ANG							
					XXXX ANG							
					XXXX ARB							
					XXXX ASTS							

A14.3. (PACAF) PACAF/SGX will consolidate responses and provide to AFRC/SGX and ANGRC for use at OSAT conference to better match Reserve and Guard units for training opportunities and ensure an appropriate AFSC composition or UTC is identified to maximize training benefits for both Reserve/ Guard units and PACAF unit.

A14.4. (PACAF) Units identified to deploy to a "region" in the Operations Plan (OPLAN), i.e. Korean Peninsula, Japan, etc. will receive higher priority to accomplish an OSAT.

A14.5. (PACAF) Requirement: PACAF medical units are expected to host "at least" one unit per fiscal year. OSATs generally occur during the summer months.

Attachment 15 (Added-PACAF)

PACAF MEDICAL READINESS ANNUAL AWARDS PROGRAM

A15.1. (PACAF) USAF Medical Expeditionary Operations/Readiness Awards.

A15.2. (PACAF) Reference: AFI 36-2856, Attachment 49.

A15.2.1. (PACAF) All PACAF Medical and Aeromedical Evacuation Units are eligible to submit nominees for the following award categories:

A15.2.1.1. (PACAF) Airman, NCO, SNCO, Officer and Manager Base Level Medical Readiness Awards: Nominees must be assigned to a base level medical readiness officer or function as of 31 December of the nomination period.

A15.2.1.2. (PACAF) Airman (rank of Airman Basic through Senior Airman)

A15.2.1.3. (PACAF) NCOs (rank of Staff Sergeant through Technical Sergeant)

A15.2.1.4. (PACAF) SNCOs (rank of Master Sergeant through Senior Master Sergeant)

A15.2.1.5. (PACAF) Officer (Rank of 2Lt through Major)

A15.2.1.6. (PACAF) Managers (civilian grade of GS 1 through 12)

A15.2.2. (PACAF) Award period is the calendar year (1 Jan through 31 Dec); therefore, the person must be assigned to a base level medical readiness position on 31 December of the calendar year the award is being written for, i.e. CY 2003, person must be assigned to position on 31 Dec 2003:

Packages are due to PACAF/SGX NLT the 15th of January – No exceptions!

Excerpts from AFI 36-2856 are included below for guidance and preparation.

A15.2.3. (PACAF) Nomination packages will include the following items and electronic versions should be submitted at all levels of review and approval. Samples of the individual award nomination packages are available in Attachment 3 and 4 AFI 36-2865.

A15.2.3.1. (PACAF) A nomination letter for an individual should be one page.

A15.2.3.2. (PACAF) Nominee’s name, rank, social security number, and brief supporting rationale.

A15.2.3.3. (PACAF) Confirmation statement there was no unfavorable information file (UIF) on individuals or team members during the award period. Individuals or team members with UIFs are not eligible for awards.

A15.2.3.4. (PACAF) Signature of nominee’s or team’s immediate supervisor.

A15.2.3.5. (PACAF) Endorsement by the nominee's chain of command and approved by the Unit Commander. Individuals may be submitted for awards that are rank specific if the individual performed the majority of the award period in the rank required by the award. For example, SSgt Jones is still eligible for the Medical Resource Management Airman of the Year Award if he/she

served in the rank of Amn for the majority of the award period. For the purposes of this AFI, “majority” is defined as more than six months.

A15.2.3.6. (PACAF) Individuals who undergo a permanent change of station (PCS) during an award period should be submitted for awards (individual and team) by the unit they were assigned to at the time of nomination. Accomplishments from a previous base are acceptable for individual awards in these cases.

Attachment 16 (Added-PACAF)

AEF AND AFWUS UTC INFORMATION

A16.1. (PACAF) All PACAF medical personnel are assigned to standard deployable UTCs or Associate (A) -UTCs. Additional information on AEF can be found in AFI 10-200.

A16.2. (PACAF) The majority of PACAF UTCs are coded DWX, meaning they are deployable "capable" UTCs for wartime, and not available for steady state requirements. See below for further explanation of AFWUS codes. For PACAF UTCs coded DWX, associated Expeditionary Air Force (EAF) Bin/ Bucket codes are E-PAC and E-ROK; these represent UTCs in the Enabler Bucket "E-PAC/E-ROK" (UTCs over/above those assigned to specific Bins/Buckets), and further defined as reserved for PACAF Fenced Forces for HUMRO/NEO or crisis response (E-PAC) or Republic of Korea (E-ROK).

A16.3. (PACAF) All PACAF medical Associate (A)-UTCs are coded AXX. The A-UTC represents the "residual" medical unit's personnel not assigned to standard deployable UTCs because they are required to support in-place OPLAN or homeland defense requirements.

A16.4. (PACAF) Other than the above AFWUS codes for PACAF UTCs, the only other AFWUS code for PACAF medical UTCs is DWS, which represents PACAF's contribution to the AEF/steady state requirements. Elmendorf (3MDG) is the primary unit with UTCs assigned to specific AEF Bins/Buckets, with some support from Misawa to Elmendorf for an EMEDS Basic Personnel Package. The primary AEF Bins (or Buckets) are AEF 1-2 and AEF 7-8. In addition, the Aeromedical Evacuation Squadron has two (2) AE crews and (2) AE kits coded as DWS and AEF Bin E-LAA, which represents "additional" or Enabler - Limited Asset Availability (LAA) capability and can be tasked to fill steady state requirements if the AEF Center (AEFC) cannot fill with postured assets in a particular AEF Bin.

First Character of AFWUS code:

D = Deployable; A=Associate

Second Character of AFWUS code:

W=Wartime Surge Available; X=Not Wartime Surge Available

Third Character of AFWUS code:

S=Steady State Available (AEF); X=Not Steady State Available

A16.5. (PACAF) The majority of PACAF medical UTCs are coded either DWX as they are assigned and "forward deployed" to PACAF theater to support wartime requirements, thus not available for steady state requirements.

A16.6. (PACAF) Mobility Folders : Personnel assigned to the following AFWUS codes are required to have a personnel readiness folder (PRF) per AFI 10-403:

- AWS or DWS
- AWX or DWX
- AXS or DXS

A16.6.1. (PACAF) PRFs must be standardized to contain, at a minimum, the following mandatory items:

A16.1.1. (PACAF) Deployment/mission orientation briefing (Use the Unclassified Unit Mission Narrative from the Unit's Designed Operational Capability (DOC) statement)

A16.1.2. (PACAF) Letter of selection for deployment position, including AEF assignment and position code. For PACAF medical personnel, this should include the UTC, AFWUS code from above and AEF Bin, i.e. AEF01, E-ROK, E-PAC, etc. from the AFWUS.

A16.1.3. (PACAF) Locally developed individual requirements checklist, including clothing. (This should reflect things like wills, powers of attorney, passport requirement, extra pair of glasses or contacts, etc.)

A16.1.4. (PACAF) Applicable appointment letters and training documentation (e.g. classified courier, weapons courier, ammunition courier, UTC, RSVs, Core Training, AF Form 1098, etc.)

A16.1.5. (PACAF) Copy of current VRed, Record of Emergency Data (much be validated by individual prior to deployment to ensure emergency contact information is correct).

A16.1.6. (PACAF) Items recommended to be maintained in the folder as optional:

ID tags and chains

Powers of attorney

Shot Record

Baggage Tags

Postal Change of Address Form

Attachment 17 (Added-PACAF)

MEDRED-C FORMAT AND GUIDANCE FOR SUBMISSION

A17.1. (PACAF) Applies to all PACAF Medical and Aeromedical Evacuation (AE) Units and deployed PACAF medical and AE personnel, whether deployed as a unit or UTC or individually. Refer to paragraphs **6.8.1.1. (Added)** thru **6.8.1.4. (Added)** for additional information on MEDRED-C reporting requirements.

A17.2. (PACAF) MEDRED-Cs provide an "up-channel" of information on USAF Medical Service units' operational readiness status, availability, and or patient care activities for units alerted for contingency operations (actual, exercise, or simulation). Reports apply to medical units influenced by unusual occurrences (e.g., natural disasters or other emergencies).

A17.3. (PACAF) Submit MEDRED-C reports to PACAF/SGX and Home Duty Location's Medical Readiness Office; **preferred method to PACAF is via E-mail to mailto:pacaf.sgx@hickam.af.mil for unclassified reports or mailto:pacaf.sgx@dsm.hickam.af.smil.mil for classified reports.**

IMPORTANT: If deployed personnel are unable to convince the lead medical unit to include their arrival and operational status in the lead unit's MEDRED-C, **ENSURE ALL DEPLOYED PERSONNEL UNDERSTAND THE REQUIREMENT TO NOTIFY THEIR PARENT UNIT'S MEDICAL READINESS OFFICE WITH THE PERTINENT INFORMATION OUTLINED IN EXAMPLE 4, MEDRED-C, SECTION C BELOW. THE PARENT UNIT WILL SEND ANY/ALL DEPLOYED STATUS INFORMATION TO PACAF/SGX AS IT BECOMES AVAILABLE.**

A17.3.1. (PACAF) **EXAMPLE 1: Section A for units/facilities alerted/notified of deployment/exercise tasking:**

Section A (Status Change) – For AEF Deployment (NOTE: Information much the same for any other type of deployments for Exercises, Humanitarian Missions or contingency operations.

(SECRET)/OPERATION ENDURING FREEDOM (AEF 1)

SUBJ: MEDRED-C, SECTION A REPORT

A1. DEPLOYMENT ALERT EFFECTIVE 051500Z JUN 03.

Line A1 Description: Nature and effective date and time of status change.

A2. 3MDG, ELMENDORF AFB ALASKA.

Line A2 Description: Number, name, and location of parent fixed facility and geographical location from which the alerted unit, flight, element or personnel will deploy.

A3. AFTH/EMEDS PACKAGES (TOTAL 60 PERSONNEL); UTCS FFEW1 (-), FFEP3, FFGKN, FFGKV, FFEP5 AND FFZ99

A3.1 FFEW1 CONSISTS OF FOLLOWING: 23 OF 25 PERSONNEL REQ'D (UTC IS MINUS (1) 4N051 AND (1) 46N3/O-3)

A3.2 FFEP5, FFGKV, AND FFGKN; ALL AFSCS WITH NO SUBSTITUTIONS

A3.3. FFEP3, SUBBED 48R3 WITH 44F3

A3.4. FFZ99 IS ONE 4D071 – NO SUBSTITUTIONS

Line A3 Description: Identity of Capability, i.e. EMEDS, MASF, AE crews, etc. or individual AFSCs if not part of a UTC alerted and/or unit type code (UTC) alerted for deployment.

A4. FFEW1 TO LANDSTUHL MEDICAL CENTER, GERMANY, ETA: 081200Z JUN 03.

A4.1. FFEP3, FFGKN, FFGKV, FFEP5, AND FFZ99 TO TALIL, IRAQ, ETA: 121500Z JUN 03

Line A4 Description: Planned employment (destination) location and estimated time of arrival (ETA).

A5. OPERATION ENDURING FREEDOM (OEF)/AEF 1.

Line A5 Description: Identification of applicable Operations Plan (OPLAN), disaster or Contingency Plan (CONPlan), Exercise Name (RSO&I 03, UFL03, etc.) or operation name (OEF, OIF, FDO, etc.)

A6. MISSION TO SUPPORT OEF SUSTAINED OPERATIONS AS PART OF AEF 1/BLUE (JUN-OCT 2003). EXPECTED TOUR LENGTH (ETL) IS 120 DAYS. ALL PERSONNEL ACCOMPLISHED ….XXXXXX JUST IN TIME TRAINING AND RECEIVED ANTHRAX AND SMALL POX VACCINATIONS AS DIRECTED BY CENTCOM REPORTING INSTRUCTIONS.

Line A6 Description: Narrative Remarks. ***Provide as complete a description of the situation and mission to be performed as possible. Be liberal and detailed with remarks… tell the story in plain language and ensure recipients of MEDRED-C will not have to call for more specifics or information.***

A17.3.2. (PACAF) **EXAMPLE 2: Section A for units/facilities undergoing natural disaster or emergency situation:**

Section A (Status Change) – For Natural disasters or other real-world emergencies.

(UNCLASSIFIED)/TYPHOON XXXX ALERT

SUBJ: MEDRED-C, SECTION A REPORT

A1. TYPHOON ALERT EFFECTIVE 051500Z JUN 03.

Line A1 Description: Nature and effective date and time of status change. Types of natural disasters or emergencies include tornados/hurricanes/earthquake/flooding, etc.; terrorist bombing or bomb threat, civil disturbances or anything that causes a status change for the medical unit's ability to provide medical care.

A2. 36MDG, ANDERSEN AFB GUAM.

Line A2 Description: Number, name, and location of parent fixed facility and geographical location from which the alerted unit, flight, element or personnel will deploy.

A3. 36 MEDICAL GROUP CLOSED DOWN FOR ALL OPERATIONS; EMERGENCIES DIRECTED TO LOCAL HOSPITAL

Line A3 Description: Identity of Capability alerted and/or affected by situation

A4. 36 MEDICAL GROUP PERSONNEL TOLD TO GO HOME AND STAY UNTIL NOTIFIED TO RETURN TO WORK; EFFECTIVE 061700Z JUN 03

Line A4 Description: Planned employment (destination) location and estimated time of arrival (ETA).

A5. TYPHOON XXXXX.

Line A5 Description: Identification of applicable Operations Plan (OPLAN), disaster or Contingency Plan (CONPlan), Exercise Name (RSO&I 03, UFL03, etc.) or operation name (OEF, OIF, FDO, Typhoon XXXX, Bomb Threat at XXXX location, etc.)

A6. 36 ABW/CC DIRECTED ALL NON-ESSENTIAL PERSONNEL TO GO HOME AND REMAIN THERE UNTIL NOTIFIED TO RETURN TO WORK. XXXX NUMBER OF MEDICAL PERSONNEL WERE ACCOUNTED FOR ON 6 JUN 03. 36 ABW 24-HOUR CONTACT NUMBER IS XXXXX. LOCAL HOSPITAL HAS EMERGENCY RESPONSE/AMBULANCE RESPONSE CAPABILITY…. AND ANY OTHER INFORMATION HOW OPERATIONS WILL CONTINUE DURING *DISASTER/ SHUT-DOWN BASE MEDICAL FACILITY.*

Line A6 Description: Narrative Remarks. ***Provide as complete a description of the situation and mission to be performed as possible. Be liberal and detailed with remarks… tell the story in plain language and ensure recipients of MEDRED-C will not have to call for more specifics or information. NOTE: For natural disasters/emergencies, etc. use Section A to report damage, disrupted communications issues, estimated completion date of damaged materiel/suystems, etc., to include a final report reflecting "back to normal operations".***

A17.3.3. (PACAF) **EXAMPLE 3: Section B for units/personnel deployments:**

Section B (Deployment) – The parent fixed facility submits the report after deployment of UTCs or individuals from their home station.

(SECRET)/OPERATION ENDURING FREEDOM/AEF 1

SUBJ: MEDRED-C, SECTION B REPORT

B1. 3MDG ELMENDORF AFB ALASKA

Line B1 Description: Number, name, and location of parent fixed facility and geographical location from which the alerted unit, flight, element or individual deployed from.

B2: 23 PERSONNEL (REFER TO MEDRED-C, SECTION A DATED 8 JUN 03 FOR AFSC BREAK-OUT) ASSIGNED TO FFEW1

B2.1: FFEP5, FFGKV, AND FFGKN, FFEP3 AND FFZ99 (REFER TO MEDRED-C, SECTION A, DATED 8 JUN 03 FOR AFSC DETAIL); 15 TOTAL PERSONNEL

Line B2 Description: Identity of UTCs, elements or personnel deployed.

B3. FFEW1 (-), LANDSTUHL MEDICAL CENTER, LANDSTUHL, GERMANY, ETA 280900Z JUN 03 VIA MIL AIR FROM BWI TO RAMSTEIN AB, GERMANY

B3.1 FFEP5, FFGKV, AND FFGKN, FFEP3 AND FFZ99, TALIL AB, IRAQ; ETA 300500Z JUN 03 VIA MIL AIR FROM BWI TO BAGHDAD INT'L AIRPORT

Line B3 Description: Planned employment (final destination) location of deploying unit/personnel and Estimated Time of Arrival (ETA).

B4. OPERATION ENDURING FREEDOM (OEF), AEF 1

Line B4 Description: Identification of OPlan, CONPlan, disaster plan, or operation name.

B5. FFEW1 (-) DEPARTED HOME STATION 151200Z JUN 03 ON COMMERCIAL AIRCRAFT WITH INITIAL DESTINATION OF BWI

B5.1 FFEP5, FFGKV, AND FFGKN, FFEP3 AND FFZ99 DEPARTED HOME STATION 251700Z JUN 03 ON COMMERCIAL AIRCRAFT WITH INITIAL DESTINATION OF BWI

Line B5 Description: Deployment/departure information for units, elements, individuals, etc. from home station

B6. FFEW1 (-) TO PROVIDE MEDICAL AUGMENTATION/SUPPORT TO LANDSTUHL MEDICAL CENTER'S STAFF IN SUPPORT OF OEF.

Line B6 Description: Narrative Remarks. Make a general assessment of the situation including any deviation from information reported in previous messages or in the normal composition or size of deployed element. Identify anticipated limiting factors.

A17.3.4. (PACAF) **EXAMPLE 4: Section C for units/personnel augmenting a lead medical unit/facility:**

Submit immediately, but not later than 24 hours after unit/personnel arrive at deployed location.

MEDRED-C, SECTION C (Employment Status and Workload Section)

(SECRET)/OPERATION ENDURING FREEDOM/AEF 1

SUBJ: MEDRED-C, SECTION C REPORT

C1. 3MDG ELMENDORF, AFB ALASKA; FFEW1 (-), 23 PERSONNEL

Line C1 Description: Identity and type of unit.

C2. LANDSTUHL MEDICAL CENTER, LANDSTUHL, GERMANY

Line C2 Description: Report the exact employment location giving the name of the town, military site/ base name, state, country, etc. If not known, indicate distance and direction from nearest town or city.

C3. ATTAINED OPERATIONAL CAPABILITY 010800Z JUL 03

Line C3 Description: Report the time in Greenwich Mean Time (GMT)/ZULU and the date the unit arrived and/or attained operational capability as a functioning unit within the deployed unit/location ***(NOTE: When individuals are "augmenting" an established medical unit or deployed lead medical unit, i.e. EMEDS, etc. ensure arrival and operational capability status is provided in MEDRED-C and PACAF/SGX is added to distribution list.)*** *THIS IS IMPERATIVE FOR THE PARENT MAJCOM TO KNOW THE STATUS OF DEPLOYED PACAF PERSONNEL.*

C4. 1/22; FFEW1 (-)

Line C4 Description: Enter total number of physicians present for duty. Enter a slash (/) followed by the total of other medical personnel present for duty

C5. N/A for units and/or personnel augmenting a medical facility or deployed medical unit (the lead medical unit will submit a MEDRED-C, Section C report to report workload…. This example is simply to ensure communication and status of deployed PACAF medical personnel to deployed locations and their arrival and operational status.

Line C5 Description: Patient Workload Data - Since Last Report. Enter numbers and slashes, as indicated below based on the type of facility:

C6. N/A (See C5 above, but replace medical with AE)

Line C6 Description: Patient Evacuation Summary. For aeromedical staging units, medical facilities operating holding beds for aeromedical evacuation, and aeromedical evacuation control centers (AECC) only.

C7. N/A for personnel only deployments

Line C7 Description: Medical Materiel Data. Report only War Reserve Materiel (WRM) stocks (by WRM alphabetical code) that have changed in materiel capability since previous submission of RCS: HAF-SG(SA)7131, WRM Medical Stock Status Report. Use project codes authorized by AFM 300-4, Volume III, ADE ME-178-1X. Follow each line entry by a numerical index from 0 to 100 to denote the percentage of materiel operationally ready.

C8. N/A for personnel only deployments

Line C8 Description: Facilities Status. Using a numerical index from 0 to 100, enter a percentage figure which represents usability of the facility. Consider loss of utilities, as well as physical plant.

C9. ALL PERSONNEL ARRIVED WITHOUT INCIDENT; ON-BASE BILLETING PROVIDED AND THERE ARE NO ISSUES OR LIMITING FACTORS AT THIS TIME. CONTACT INFORMATION FOR ELMENDORF'S DEPLOYED PERSONNEL IS LT COL RESPONSIBLE AND CAN BE REACHED DURING THE DAY AT DSN 555-5555 OR EVENINGS AT COUNTRY CODE 011-345-567-5678.

Line C9 Description: Narrative Remarks. Include: a. Commander's assessment of significant operational constraints. b. Limiting factors which adversely affect mission accomplishment. c. Include Date Time Group of messages/requests generated to effect emergency actions such as replacement of personnel, materiel resupply, and blood resupply.

C10. N/A (Until unit/personnel plan to redeploy to home station). Provide as much information as possible, to include time and date of scheduled departure, on what means of transportation and ETA at permanent duty station.

Line C10 Description: Use only to indicate a final report.

A17.3.5. (PACAF) **EXAMPLE 5: Section C for Lead medical units, i.e. EMEDS packages:**

Submit MEDRED-C, Section C Reports as follows:

(1) Once operational at employment location

(2) Daily as of 2359 local

(3) Upon a change of 25 percent in any element of the original report

(4) Update status when appropriate or as required.

NOTE: If the medical unit comes under the influence of an unusual occurrence such as a natural disaster, fire, or bomb explosion. Continue reporting daily until higher headquarters directs.

MEDRED-C, SECTION C (Employment Status and Workload Section)

(SECRET)/TYPHOON HANNIBELL

SUBJ: MEDRED-C, SECTION C REPORT

C1. 374MDG YOKOTA AB JAPAN: EMEDS Basic

Line C1 Description: Identity and type of unit.

C2. ANDERSEN AB, GUAM

Line C2 Description: Report the exact employment location giving the name of the town, military site/ base name, state, country, etc. If not known, indicate distance and direction from nearest town or city.

C3. ATTAINED OPERATIONAL CAPABILITY 100800Z DEC 02

Line C3 Description: Report the time in Greenwich Mean Time (GMT)/ZULU and the date the unit arrived and/or attained operational capability as a functioning unit within the deployed unit/location

C4. 7/18; FFDAB, FFEP1, FFEP2, FFEP6, FFGL2, FFGL3, FFMFS

Line C4 Description: Enter total number of physicians present for duty. Enter a slash (/) followed by the total of other medical personnel present for duty

C5. 4/0/0/2/0/0// (first day of operational capability; totals after "//" same as daily totals before the "//")

Line C5 Description: Patient Workload Data - Since Last Report. Enter numbers and slashes, as indicated below based on the type of facility:

C5a. N/A (EMEDS workload is reflected in Line C5b)

Line C5a Description: For Second Echelon Medical Treatment Units (2E), Squadron Medical Elements with or without Air Transportable Clinics (ATC), and Clinics (including Residual Medical Clinics): Number returned to duty (RTD), transferred, or expired since last report followed by a double slash (//) and cumulative totals for each category to date. Use a single slash (/) between each category: Example: Medical unit workload was 10 patients RTD/3 patients transferred/2 expired//20 RTD total/34 total transferred/5 total expired. The entry would appear as: C5. 10/3/2//20/34/5.

C5b.

Line C5b Description: For CONUS Casualty Reception Hospitals (CRH), Expeditionary Medical Support (EMEDS), to include any size from Basic to AFTH; Convalescent Care Centers and CONUS/OCONUS Hospitals with expansion bed missions: Beds available, beds Occupied, number admitted, returned to duty, transferred, or expired since last report followed by a double slash (//) Patients Admitted, Returned to Duty, Transferred, and Expired to date. Use single slash (/) between each category. Example: Medical unit had 11 beds available/29 beds occupied/12 patients admitted/48 patients RTD/0 patients transferred/8 patients expired//35 total admissions to date/84 patients total RTD/20 total patients trans-

fers/23total patients expired. The entry would appear as: C5. 11/ 29/12/48/0/8//35/84/20/23. Patients transferred-in//45 total transfers-out/215 total transfers-in. The entry would appear as: C5. 250/98/20/ 60//45/215.

C6. N/A (Only for AE units or med facilities with holding beds for AE)

Line C6 Description: Patient Evacuation Summary. For aeromedical staging units, medical facilities operating holding beds for aeromedical evacuation, and aeromedical evacuation control centers (AECC) only. All others will indicate N/A.

Line 6a Description. Evacuated within theater and evacuated to CONUS since last report. Each category is broken down into litter and ambulatory figures using a single slash (/). Use a semi-colon (;) to separate the categories of evacuated within theater from evacuated to CONUS and follow with a double slash (//). Following the (//) provide cumulative figures for each category to date. Example: Medical unit reports 100 litter/500 ambulatory patients evacuated within theater; 98 litter/600 ambulatory patients evacuated to CONUS// 198 total litter/900 total ambulatory patients evacuated within theater; 500 total litter/1000 total ambulatory patients evacuated to CONUS. The entry would appear as: C6A. 100/500; 98/600//198/ 900; 500/1000.

Line 6b Description. Awaiting evacuation within theater and awaiting evacuation to CONUS since last report. Each category is broken down into litter and ambulatory figures using a single slash (/). Use a semi-colon (;) to separate awaiting evacuation within theater from awaiting evacuation to CONUS. Example: Medical unit reports 230 patients awaiting evacuation within theater, (175litter/55 ambulatory); 145 patients awaiting evacuation to CONUS (120 litter/25 ambulatory). The entry would appear as: C6B. 175/55; 120/25.

C7. VU-92; VV-90; EA-97; EB-95; IT-87; IV-91

Line C7 Description: Medical Materiel Data. Report only War Reserve Materiel (WRM) stocks (by WRM alphabetical code) that have changed in materiel capability since previous submission of RCS: HAF-SG(SA)7131, WRM Medical Stock Status Report. Use project codes authorized by AFM 300-4, Volume III, ADE ME-178-1X. Follow each line entry by a numerical index from 0 to 100 to denote the percentage of materiel operationally ready.

C8. 90 (One section of EMEDS facility that unusable due to water damage, ECD: 151200Z DEC 02)

Line C8 Description: Facilities Status. Using a numerical index from 0 to 100, enter a percentage figure which represents usability of the facility. Consider loss of utilities, as well as physical plant.

C9. ALL PERSONNEL ACCOUNTED FOR; ALL EQUIPMENT ARRIVED WITHOUT DAMAGE OR INCIDENT, SET UP AND OPERATIONAL, EXCEPT THE ONE SECTION MENTIONED IN LINE C8 ABOVE. ANTICIPATE THAT SECTION BEING OPERATIONAL NLT 15 DEC 02. PERSONNEL ARE BILLETED IN TENT CITY ON ANDERSEN AB, GUAM. EMEDS COMMANDER….

COL SMITH OR THE ADMINISTRATOR, MAJOR JONES CAN BE CONTACTED VIA E-MAIL AT **mailto:374AEW/EMEDS @ANDERSEN.AF.MIL** OR **mailto:374AEW/EMEDS@DMS.ANDERSEN.AF.SMIL.MIL**. 374EMEDS/CC AND ADMINISTRATOR CAN BE CONTACTED BY PHONE AT DSN 315-456-1234/5678. THE 24-HOUR CONTACT NUMBER IS 315-666-8989 IN THE COMMAND POST.

Line C9 Description: Narrative Remarks. Include:

a. Commander's assessment of significant operational constraints.

b. Limiting factors which adversely affect mission accomplishment.

c. Include Date Time Group of messages/requests generated to effect emergency actions such as replacement of personnel, materiel resupply, and blood resupply.

C10. N/A "Until unit/personnel plan to redeploy to home station". Provide as much information as possible, to include time and date of scheduled departure, on what means of transportation and ETA at permanent duty station.

Line C10 Description: Use only to indicate a final report.

Attachment 18 (Added-PACAF)

DISASTER TEAM BINDER REQUIREMENTS

A18.1. (PACAF) This annex outlines the minimum required items to be maintained within the disaster team chief's team binder.

A18.1.1. (PACAF) Team Chief Appointment Letter – Signed by MDG/CC.

A18.1.2. (PACAF) Team CONOPS or PURPOSE.

A18.1.2.1. (PACAF) Reporting location and alternate assembly points.

A18.1.2.2. (PACAF) Administrative Responsibilities.

A18.1.3. (PACAF) Team recall roster, which entails contact information for both on and off duty.

A18.1.4. (PACAF) Key Phone Numbers such as the MCC and other supporting disaster teams.

A18.1.5. (PACAF) MRCP.

A18.1.6. (PACAF) Checklists supporting the disaster team's mission.

A18.1.7. (PACAF) Listing of supplies and equipment required to support the team's mission.

A18.1.8. (PACAF) Team training documents, to include the annual training calendar, training objectives and lesson plans, exercise objectives, and training attendance.

A18.1.8.1. (PACAF) Provisions must be made to ensure personnel who missed the initial training session can make it up.